OUTPATIENT ENDOSCOPY INSTRUCTIONS

Patient Name: _____

Date of Birth: _____

Procedure scheduled for:

☒ **Hoag Endoscopy Center** 949-698-1339

☐ **Newport Beach Endoscopy Center** 949-646-6999

☐ **Upper Endoscopy Procedure** ☐ **Lower Endoscopy Procedure**

Date: _____ **Check in Time**: _____ A.M./P.M. **Procedure**: _____ A.M./P.M.

If your medical history includes any of the following, please call the facility:

- Active Shingles
- MRSA (Methicillin-resistant Staphylococcus aureus)
- Clostridium difficile (Often called C. difficile or C. diff.)
- Dialysis

Preparing for your procedure

- **Items to bring** with you on the day of the procedure:
  - Completed Patient History Questionnaire
  - Completed Patient's Home Medication List
  - Insurance cards and another form of ID
  - Any payment as required by your insurance provider (cash, check, credit card)
- Bring this form with you on the day of the procedure.
- Do not wear nylons/stockings, body piercing or jewelry.
- Wear loose clothing and low-heeled shoes. Your clothes will be folded and placed in a plastic belonging bag during your procedure.
- Please make sure to follow your procedure instructions that you received from your doctor. If you should have any problems or questions regarding your procedure instructions, please contact your doctor.
- Due to sedation medications during the procedure, you **must have someone drive you home or your procedure will be canceled. NOTE: The driver cannot be a cab or taxi.**
- If you have family members that want to speak with the physician, please have them wait in the waiting room. Family waiting can check in with front-desk staff in the lobby.

Center Information

- If you have an Advance Directive or Living Will, please bring a copy with you the day of the procedure. The document will be placed in your medical record in the event that there is a patient transfer or emergent situation. If you need additional information regarding Advance Directives will be happy to provide you with official State Advance Directive forms.
- The following physicians have ownership in Hoag Endoscopy Center and Newport Beach Endoscopy Center: Donald Abrahm, M.D., David J Kaufman, D.O., Christopher Evan Lee, M.D., Babak N. Rad, M.D., Abhay S. Parikh, M.D., S. Patricia Tsai, M.D., Lino J. DeGuzman, M.D., Daniel A. Ng, M.D., Richard Quist, M.D., Kathryn Ross, M.D., and Homeira Mehrabian, M.D.

☒ HOAG ENDOSCOPY CENTER

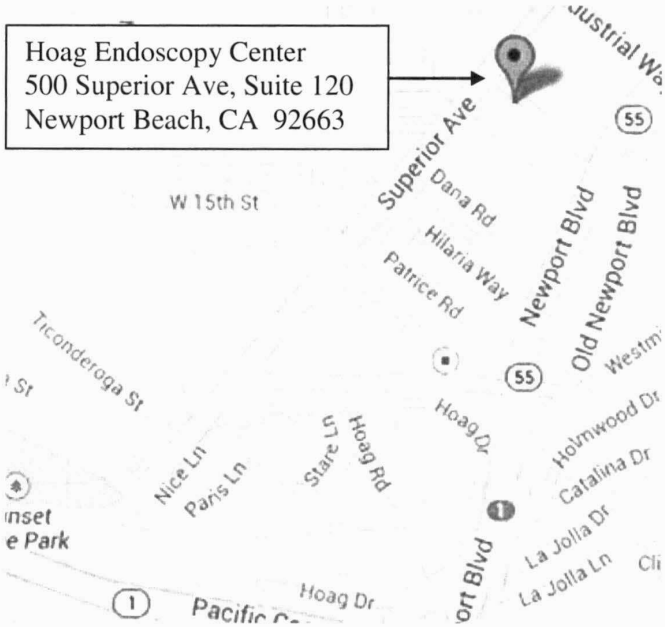
Parking

Hoag Endoscopy Center at Hoag Health Center – Newport Beach

There is ample parking in both parking structures at Hoag Health Center – Newport Beach. Registration is located on-site in the Hoag Endoscopy Center.

Questions?

Hoag Endoscopy Center
949-698-1339



☐ NEWPORT BEACH ENDOSCOPY CENTER

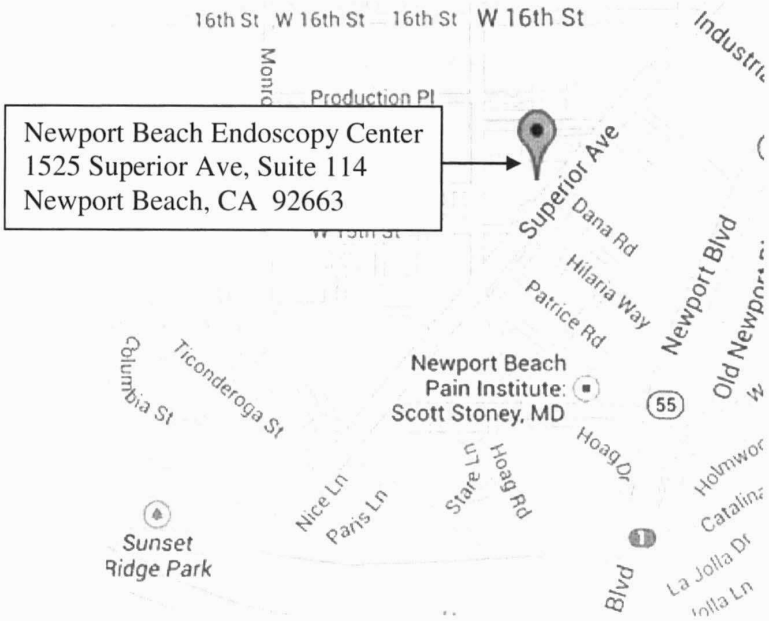
Parking

Newport Beach Endoscopy Center – 1525 Superior Ave

There is ample in parking in both the top floor level parking as well as in the lower garage. Registration is located on-site in the Newport Beach Endoscopy Center.

Questions?

Newport Beach Endoscopy Center
949-646-6999



PATIENT HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____ Age: _____

Stated Height: _____ Stated Weight: _____ Primary Language: _____ Driver(s) Name: _____

Driver(s) Telephone Numbers: 1st Number ( ) _____ 2nd Number ( ) _____

Procedure: _____ Date of Procedure: _____

Physician performing procedure: _____ Primary Care Physician: _____

Internist: _____ Last seen: _____ Cardiologist: _____ Last seen: _____

ALLERGIES and ALLERGY REACTIONS:

LIST PREVIOUS SURGERIES: Year Complications Type of Anesthesia

LIST PREVIOUS CARDIAC/MEDICAL PROCEDURES: angioplasty/stent placement, echocardiogram, stress test, pacemaker or defibrillator model/brand #, and where done

Procedure Year

Please check appropriate box in each section below:

CARDIOVASCULAR	**Yes**	**No**
Hypertension	☐	☐
Heart Attack – Date:_____	☐	☐
Coronary Artery Disease	☐	☐
Cardiomyopathy	☐	☐
Congestive Heart Failure	☐	☐
Arrhythmias i.e. A-Fib	☐	☐
Rheumatic Fever	☐	☐
Heart Valve problems	☐	☐
Heart murmur	☐	☐
Carotid Artery Disease	☐	☐

	Yes	**No**
Angina/Chest Pain	☐	☐
Pain or shortness of breath when walking 2 blocks or climbing 1 flight of stairs	☐	☐
High Cholesterol	☐	☐
Poor Circulation in lower extremities	☐	☐
Family history of heart disease (age of onset)	☐	☐
Father _____ Mother _____ Siblings _____		

PULMONARY	**Yes**	**No**
Asthma	☐	☐
COPD/Bronchitis/Emphysema (circle)	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐

	Yes	**No**
Blood clots in lungs or legs	☐	☐
Sleep Apnea	☐	☐
Chronic Cough	☐	☐
Oxygen Use	☐	☐

Addressograph

GASTROINTESTINAL	**Yes**	**No**
Hiatal Hernia	☐	☐
Ulcers/GERD/Gastric Reflux (circle)	☐	☐
Gallstones	☐	☐
Liver Disease	☐	☐
Hepatitis A, B or C	☐	☐

GENITOURINARY	**Yes**	**No**
Urinary Tract Infections	☐	☐
Kidney Stones	☐	☐
Prostate Disease	☐	☐
Penile Prosthesis	☐	☐
Dialysis	☐	☐

HEMATOLOGIC	**Yes**	**No**
Anemia	☐	☐
Bleeding Disorders	☐	☐
Blood Diseases i.e. Leukemia	☐	☐
Blood Transfusions	☐	☐
Easy Bruising	☐	☐

ENDOCRINE	**Yes**	**No**
Diabetes	☐	☐
Hypo/Hyperthyroidism	☐	☐
Hypoglycemia	☐	☐
Glaucoma	☐	☐

NEUROLOGIC	**Yes**	**No**
Stroke/TIA's	☐	☐
Seizures	☐	☐
Multiple Sclerosis	☐	☐
Myasthenia Gravis	☐	☐
Paralysis	☐	☐
Muscle Weakness	☐	☐
Headache	☐	☐
Fainting	☐	☐
Numbness	☐	☐

PAIN	**Yes**	**No**
Rheumatoid arthritis	☐	☐
Osteoarthritis	☐	☐
Chronic Pain Treatment	☐	☐
Back/Neck Pain	☐	☐
Artificial Joints	☐	☐

Location: _____

GENERAL HEALTHCARE	**Yes**	**No**
Cancer	☐	☐
Location: _____		
Radiation Therapy	☐	☐
Chemotherapy	☐	☐
Immune Deficiency	☐	☐
TB Skin Test	☐	☐
☐ Positive ☐ Negative ☐ Unknown		

	Yes	**No**
Social History:		
Do you drink alcohol? Amount: _____	☐	☐
Do you smoke?	☐	☐
Did you ever smoke? Years: _____	☐	☐
Have you smoked in the past 12 months?	☐	☐
Do you use recreational drugs?	☐	☐
Type: _____		
If female: possibility of pregnancy?	☐	☐
Last menstrual period: _____		
History of Malignant Hyperthermia (MH)	☐	☐
Family history of anesthesia problems or MH (circle)	☐	☐

SURGICAL INFORMATION	**Yes**	**No**
Do you have any specific needs?	☐	☐
Hearing	☐	☐
Vision	☐	☐
Living alone	☐	☐
Transportation	☐	☐
Insurance	☐	☐
Do you exercise?	☐	☐
Type: _____		

	Yes	**No**
Do you need information on:		
Current surgery	☐	☐
Medications	☐	☐
Activities	☐	☐
Home Care	☐	☐
Do you wear contact lenses?	☐	☐
Do you have caps, bridges, dentures or loose teeth?	☐	☐

_____ [Patient/Parent/Conservator/Guardian]

_____ [If completed by other than patient, indicate relationship]

_____ [Date]

THIS SECTION FOR FACILITY PERSONNEL USE ONLY

_____ [Reviewed by Assessment Nurse] _____ [Date] _____ [Time]

MEDICATION RECONCILIATION

Acknowledgement: I confirm that this is a complete and accurate list of my (patient's) current medications, to the best of my knowledge, including prescription and over the counter drugs. I understand that healthcare providers will make medical decisions based on this information.

ALLERGIES/REACTION: List all ***allergies*** to medications, herbs, food, latex, IV contrast, and other. List all ***reactions*** next to allergy. (Ex:Ibuprofen/Rash, hives)		
☐ None		
1.	4.	7.
2.	5.	8.
3.	6.	9.

CURRENT MEDICATIONS: List your prescriptions, herbal, and over-the-counter medicines you take.
☐ None ☐ Patient poor historian/No family present/Unable to obtain information at this time

Medication Name	Dose	Frequency	Reason	Last Dose	**On Discharge** Stop	**On Discharge** Continue (Next Dose)
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	

Noted: RN Signature	**Date:**	**Time:**

Discharge – Additional Prescriptions and Specific Medication Instructions:
☐ No changes in prescription and non-prescription medications.
1.
2.

PATIENT INSTRUCTIONS: Above is the list of medications you indicated that you are currently taking. Resume taking your current medications, noting any checked boxes which indicate a change in your current medication regimen. Remember to follow the new medication instructions as directed. All medication changes or new prescriptions will be relayed to your referring physician. Please contact the physician who prescribed your medications if you have any questions. Your signature below means you understand these instructions.

_____ [Patient/Parent/Conservator/Guardian]	_____ [Date]	_____ [Time]	A.M./P.M.
_____ [Physician Signature]	_____ [Date]	_____ [Time]	A.M./P.M.

MEDICATION RECONCILIATION Original – Patient Photocopy – Chart

Form 3278 Rev 7/9/15