

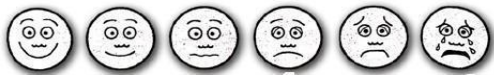
NORMAN ENDOSCOPY CENTER, LLC
ENDOSCOPY PRE-PROCEDURE RECORD

patient label

Height _____ Weight _____ BMI _____ ☐ Male ☐ Female

Y	N	DO YOU HAVE, OR HAD, A HISTORY OF THE FOLLOWING:	LIST ALL PREVIOUS SURGERIES:
		Heart trouble: <input type="checkbox"/> heart attack, date _____ <input type="checkbox"/> murmur, <input type="checkbox"/> CHF <input type="checkbox"/> chest pain (angina), <input type="checkbox"/> pacemaker, <input type="checkbox"/> defibrillator, <input type="checkbox"/> irregular heartbeat <input type="checkbox"/> valve replacement, <input type="checkbox"/> stent type _____, <input type="checkbox"/> other _____	1 2 3
		High blood pressure: <input type="checkbox"/> treated with medications, <input type="checkbox"/> low BP	4
		Stroke: date _____, list any lasting effects _____	5
		Stomach/colon: <input type="checkbox"/> abdominal pain, <input type="checkbox"/> dysphagia <input type="checkbox"/> IBS <input type="checkbox"/> ulcer, <input type="checkbox"/> reflux/GERD/heartburn, <input type="checkbox"/> esophageal varices, <input type="checkbox"/> family history <input type="checkbox"/> resection, <input type="checkbox"/> ostomy, <input type="checkbox"/> diarrhea, <input type="checkbox"/> bleeding, <input type="checkbox"/> Crohn's, <input type="checkbox"/> screening <input type="checkbox"/> Barrett's esophagus, <input type="checkbox"/> nausea/vomiting, <input type="checkbox"/> other _____	6 7 8 9
		Lung Disease: <input type="checkbox"/> asthma, <input type="checkbox"/> COPD/emphysema, <input type="checkbox"/> sleep apnea <input type="checkbox"/> snoring <input type="checkbox"/> recent bronchitis <input type="checkbox"/> abnormal chest xray, date _____	10
		Tuberculosis: <input type="checkbox"/> bloody sputum <input type="checkbox"/> recent wt loss <input type="checkbox"/> night sweats <input type="checkbox"/> persistent cough, <input type="checkbox"/> +TB test, date _____, treated yes/no	Date of last colonoscopy _____, EGD _____ Vaccine year, if applicable: influenza _____ COVID-19 _____
		Recent exposure to: HIV, measles, chicken pox, influenza, shingles, Covid-19? List _____	Have you ever had abnormal reaction or ill effect from anesthesia or sedation? <input type="checkbox"/> no <input type="checkbox"/> yes, _____
		Have you had MRSA, VRE, Creutzfeld-Jacob Disease?	History of difficult vein access? <input type="checkbox"/> no <input type="checkbox"/> yes, _____
		Liver disease: <input type="checkbox"/> cirrhosis, or <input type="checkbox"/> hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	List pertinent medical history not addressed: _____
		Kidney / Bladder Disease: <input type="checkbox"/> incontinence, <input type="checkbox"/> other _____	Do you use nicotine? <input type="checkbox"/> yes <input type="checkbox"/> past use <input type="checkbox"/> never Packs/day? _____ years of use? _____ age quit? _____
		Diabetes: <input type="checkbox"/> oral meds, <input type="checkbox"/> insulin dependent, <input type="checkbox"/> diet controlled	Alcohol, medical marijuana, recreational drug use? <input type="checkbox"/> yes <input type="checkbox"/> no, Use _____ per day, week, month (circle one)
		Abnormal bleeding: <input type="checkbox"/> blood thinners, <input type="checkbox"/> sickle cell trait, <input type="checkbox"/> other _____	I testify that the above information is complete & accurate so that I may be provided a safe procedure outcome.
		Cancer: explain type/treatment _____ <input type="checkbox"/> port	Patient Signature _____
		Epilepsy or Seizure disorder? Explain _____	
		Physical limitations? Explain _____	
		Mental, emotional or behavioral problems?	
		Learning difficulties or unable to read?	
		Female history: could you be pregnant now? <input type="checkbox"/> yes <input type="checkbox"/> no last menstrual period _____ Breastfeeding? <input type="checkbox"/> yes <input type="checkbox"/> no	Informant _____ Collected by _____ Date _____

(area below for office use only)

DAY OF PROCEDURE / PRE-PROCEDURE ASSESSMENT						
Procedure Date		Prep Area Arrival Time		NPO @		
Name & DOB verified <input type="checkbox"/> yes <input type="checkbox"/> no		Temp	BP	Pulse	Resp	SpO ₂
Procedure verified / permit signed <input type="checkbox"/> yes <input type="checkbox"/> no						
Clear colon prep results <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a						
Dentures <input type="checkbox"/> yes <input type="checkbox"/> no, Jewelry <input type="checkbox"/> yes <input type="checkbox"/> no						
Glasses <input type="checkbox"/> yes <input type="checkbox"/> no, disposition _____		FSBS _____ (65-115) <input type="checkbox"/> n/a		PAIN SCALE  0 1-2 3-4 5-6 7-8 9-10 If pain, describe _____		
		Current Narcotic / Benzodiazepine use? <input type="checkbox"/> yes <input type="checkbox"/> no if yes, list _____				
Nursing System → Assessment X = as stated, O = see notes for explanation						
Neurological	alert/oriented x 4, speech clear/understandable	<input type="checkbox"/> Patient acknowledges understanding of procedure <input type="checkbox"/> Procedure & discharge instructions reviewed with patient Patient accompanied by _____				
Cardiovascular	Regular apical pulse, peripheral pulse palpable. No significant peripheral edema					
Pulmonary	CTA. Respirations regular, unlabored. Nail beds & mucous membranes pink/moist	IV catheter: <input type="checkbox"/> 20g <input type="checkbox"/> 22g <input type="checkbox"/> 24g <input type="checkbox"/> n/a site _____ # attempts _____ by _____				
Integumentary	Skin color normal. Skin warm, dry & intact	1% intradermal xylocaine used? <input type="checkbox"/> yes <input type="checkbox"/> no				
Musculoskeletal	Moves all extremities. No muscle weakness	<input type="checkbox"/> 500ml NSS <input type="checkbox"/> saline lock <input type="checkbox"/> NA <input type="checkbox"/> other _____				
Emotional	<input type="checkbox"/> calm <input type="checkbox"/> anxious <input type="checkbox"/> agitated <input type="checkbox"/> withdrawn	additional medication given? <input type="checkbox"/> yes <input type="checkbox"/> no				
Psychosocial	<input type="checkbox"/> pediatric (14-18 years) <input type="checkbox"/> adult <input type="checkbox"/> geriatric	medication name: _____				
Airway	Neck has full ROM, jaw/mouth moves freely and opens wide	dose administered _____ time _____ route _____ initials _____				
Additional Nursing Comments: _____						
Signature(s) / initials: _____ / _____ / _____						