120 W. Center Street
W. Bridgewater, MA 02379
508-586-8700
commonwealthendoscopy.com

PRE-PROCEDURE ASSESSMENT

PATIENT NAME ____ / REASON FOR EXAM ______________________________

PRIMARY CARE PHYSICIAN ____

PERSONAL HISTORY (SELF)	YES	NO	EXPLANATION, IF YES
HEART DISEASE / MURMER / HEART ATTACK	______	______	________________
ANGINA	______	______	________________
HIGH BLOOD PRESSURE	______	______	________________
BLEEDING/CLOTTING PROBLEMS	______	______	________________
BREATHING/LUNG PROBLEMS	______	______	________________
SEIZURES/STROKES/EPILEPSY	______	______	________________
ANEMIA	______	______	________________
LIVER/KIDNEY DISEASE	______	______	________________
HISTORY OF CANCER (SELF)	______	______	________________
DIABETES	______	______	________________
THYROID PROBLEMS	______	______	________________
ARTHRITIS/LIMITATIONS OF MOVEMENT	______	______	________________
IMPLANTED PACEMAKER / DEFIBRILLATOR	______	______	________________
PREGNANT	______	______	________________
DIARRHEA/CONSTIPATION	______	______	________________
TROUBLE SWALLOWING/FOOD STICKING	______	______	________________
SMOKE/DRINK ALCOHOL -- IF YES, AMOUNT	______	______	________________
RECREATIONAL DRUG USE	______	______	________________
PAST SURGICAL HISTORY ________________	______	______	________________
________________	______	______	________________
________________	______	______	________________
OTHER ________________	______	______	________________

Have you or any family member experienced problems with anesthesia or sedation? _________ NO ________ YES, EXPLAIN

____

**** DO NOT STOP ASPIRIN**
**** UNLESS OTHERWISE DIRECTED BY THE DOCTOR, TAKE ALL YOUR MEDICATIONS**
**** PLEASE REVIEW THE INSTRUCTIONS YOU RECEIVED FROM YOUR DOCTOR'S OFFICE.**
**** NO IBUPROFEN / ARTHRITIS PRODUCT OR PRODUCTS CONTAINING THESE FOR THREE DAYS PRIOR TO THE PROCEDURE WITHOUT PHYSICIAN APPROVAL.**
**** IF YOU USE INHALERS, BRING THEM WITH YOU THE DAY OF YOUR PROCEDURE**

*** PLEASE FILL OUT MEDICATIONS ON BACK.**
TYPED LISTS ARE NOT ACCEPTABLE.

It is mandatory to have a friend or family member drive you home. We do not allow a taxi, uber driver or any form of transportation unless you have a friend or family member to accompany you.

Pre Op Nurse Sign: ______________________________

Date: ______________________________

PATIENT MEDICATION RECONCILIATION Form

Commonwealth Endoscopy Center

Name:	Date of Birth:	Age:

Allergies/Sensitivities: ☐ Yes ☐ No known allergies	Latex Allergy ☐ No ☐ Yes ☐ Testing performed for Latex allergy

Allergy/Sensitivity (Drug/Other)	Reaction	Allergy/Sensitivity (Drug/Other)	Reaction

Current Prescriptive Medications.

Name of Medication (print please)	Dose	Last Dose Taken/Time	How Often	Continue After Discharge	Stop After Discharge

Herbals, Vitamins, Supplements, Non-Prescriptive Drugs.

Name of Medication (print please)	Dose	Last Dose Taken/Time	How Often	Continue After Discharge	Stop After Discharge

Signature of person filling out form____**Date:**___________________________

New Medications or New Dosages you should take after discharge.

Name of Medication (print please)	Dose	How Often

Signature of Patient/Responsible Person:_________________________________**Date:**___________________________

Nurse Signature:____**Date:**___________________________

Physician Signature:____**Date:**___________________________