



3 Washington St
Suite 110
North Easton, MA 02356

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: _____