ADHEC

Name:_____ Date of Birth: _____

Primary Care/Referring MD: _____

PAST OR PRESENT MEDICAL PROBLEMS ☐ NONE

Gastrointestinal
☐Abdominal Adhesions
☐Anemia
☐Barrett's Esophagus
☐Celiac Disease
☐Chronic Constipation
☐Chronic Diarrhea
☐Chronic Liver Disease
☐Colitis
☐Crohn's Disease
☐Difficulty Swallowing
☐Diverticulosis / Diverticulitis
☐Esophageal Cancer
☐Esophageal Stricture
☐Esophagitis
☐Gallstones
☐Gastric Cancer
☐Gastritis
☐Heartburn/Reflux
☐Hiatal Hernia
☐Irritable Bowel Syndrome
☐Loss of Appetite
☐Milk Intolerance
☐Nausea / Vomiting
☐Personal/Family History Colon Cancer
☐Personal/Family History Colon Polyps
☐Pancreatic Cancer
☐ Recent Weight Loss: Amount_____lbs.
☐Stomach or Duodenal Cancer
☐Stomach Ulcers
☐Other: _____

Cardiovascular
☐Coronary Artery Disease
☐Coronary Stents
☐Defibrillator
☐Heart Attack
☐High Blood Pressure
☐Irregular Heartbeat
☐Pacemaker
☐Peripheral Vascular Disease
☐Stroke / Transient Ischemic Attack (TIA)
☐Valvular Heart Disease
☐Other: _____

Pulmonary
☐Asthma
☐Chronic Cough
☐COPD / Emphysema
☐Lung Cancer
☐Sleep Apnea (CPAP) _____
☐Smoker: ☐ Yes ☐ No
Date Stopped_____
☐Other: _____

Infectious Disease
☐Genital Herpes
☐Hepatitis
☐HIV / AIDS
☐MRSA
☐Shingles
☐Tuberculosis
☐Other:_____

Other
☐Breast Cancer
☐Diabetes
☐Endometriosis
☐Fibromyalgia
☐Kidney Disease
☐Mental Health Problems
☐Prostate Cancer
☐Prostate Enlargement
☐Seizures
☐Skin Problems
☐Thyroid
☐Other: _____

Recent or Past History of:
☐ Alcohol: ☐ Yes ☐ No
Amount:_____
☐ Drugs: ☐ Yes ☐ No
Amount:_____
☐ Tobacco: ☐ Yes ☐ No
Amount:_____

Surgeries: _____
_____
_____
_____
_____

Previous Problems with Anesthesia

Sedation: ☐ Yes ☐ No

Egg Allergy: ☐ Yes ☐ No

Latex Allergy: ☐ Yes ☐ No

ALLERGIES: ☐ Yes ☐ No
_____
_____

COMMUNICATION: (Circle all that apply)
English Spanish Sign Speech Problems Visual Impairment Hearing Loss
Other:_____

YOU MUST HAVE AN ADULT PRESENT DURING YOUR PROCEDURE OR RISK CANCELLATION.

Responsible adult to drive patient home? Name:_____ Phone #: _____
Person to assist with care at home for the next 24 hours? ☐ Yes ☐ No
May discharge instructions be given to driver? ☐ Yes ☐ No

****Please remove all jewelry, cell phone, glasses (if appropriate), wallet, etc. and leave with your driver before you are seen by the pre-op nurse. Please remind your nurse of any caps, crowns, dentures, loose teeth, etc. Thank-you!**

Are you currently involved in a clinical trial or research study? ☐ Yes ☐No
If Yes, Where? _____

Form completed by: _____

Phone # to call patient a day or so following the procedure:_____

Patient's Communication Preferences Regarding their PHI

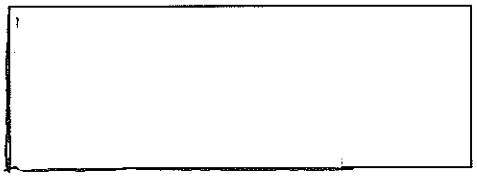
Telephone Communication Preferences

Home # _____

Work # _____

Mobile # _____

Other _____



E-Mail Communication Preferences

Email Address_____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that ADHEC, its legal agents, or affiliates may use the telephone numbers provided to send me a text notification, call using a pre- recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device.
If an email address has been provided, ADHEC, its legal agents, or affiliates may contact me with an email notification regarding my care, our services, or my financial obligation.

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you receive may contain your personal information. If you would like us to contact you by text message please sign this consent below. If you consent to receiving text messages you also agree to promptly update ADHEC when your mobile phone number changes. You are not required to authorize the use of text messaging and a decision not to sign this portion of the authorization will not affect your health care in any way.

_____

Patient's Signature for consent to text message

Mail Communication Preferences

May we send mail to your home address? ***(If no, please provide an alternate mailing address below.)***

_____

_____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

	Name:	**Telephone**
☐ Spouse	_____	_____
☐ Caretaker	_____	_____
☐ Child	_____	_____
☐ Parent	_____	_____
☐ Other	_____	_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____

Patient or Personal Representative Signature **Date**

_____ _____ _____

Printed Name **Relationship to Patient**

ADHEC

ALLERGY	REACTION
Latex Allergy ☐Yes ☐ No	Hgt:__________ Wt:__________

LIST BELOW ALL SCHEDULED AND AS NEEDED MEDICATIONS
INCLUDE OVER-THE-COUNTER, HERBAL MEDICATIONS, INHALERS, EYE DROPS, OINTMENTS, etc.

MEDICATION NAME	DOSE *Please check*	ROUTE	FREQUENCY CIRCLE HOW MANY TIMES A DAY	LAST TAKEN
	mg ☐ mcg ☐ units ☐		1 2 3 or 4 times a Day	
	mg ☐ mcg ☐ units ☐		1 2 3 or 4 times a Day	
	mg ☐ mcg ☐ units ☐		1 2 3 or 4 times a Day	
	mg ☐ mcg ☐ units ☐		1 2 3 or 4 times a Day	
	mg ☐ mcg ☐ units ☐		1 2 3 or 4 times a Day	
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	mg ☐ mcg ☐ units ☐		1 2 3 or 4 times a Day	

- **Refer to Discharge Instructions for any additional medication usage or prescriptions given today**

SIGNATURE OF PERSON LISTING MEDICATIONS: ______________________________

Confirmed by: ______________________________

MD Signature: ______________________________