Alberta Health Services

Endoscopy Pre-Procedure Patient Information (Edmonton Zone)

Affix patient label within this box

Endoscopy Pre-Procedure Patient Information

This form has been completed by:
☐ Patient ☐ Interpreter ☐ Legal Guardian ☐ Healthcare Agent

Print Name_____ Signature_____

Date | **Time** | **Prep Room**

Which procedure are you here for?
☐ Gastroscopy ☐ Colonoscopy ☐ ERCP (endoscopic retrograde cholangiopancreatography)
☐ Sigmoidoscopy ☐ Bronchoscopy ☐ Endoscopic Ultrasound ☐ Other:_____

Why do you need this procedure?

Have you read the patient information sheet provided by your doctor? Yes ☐ No ☐
Have you completed a bowel preparation? Yes ☐ No ☐ N/A ☐
Do you have further questions about the scheduled procedure? Yes ☐ No ☐

Do any members of your family (parents, children, brothers or sisters, blood relatives) have ulcers, bowel cancer or other intestinal or liver diseases? Yes ☐ No ☐

Allergies (please add a page if you need more space to list your allergies):

When is the last time you had anything to:
☐ drink _____
☐ eat _____

Height _____cm / inches **Weight**_____ lb / kg

In the past year my weight has ☐ remained the same
☐ increased by _____lb / kg
☐ decreased by _____ lb / kg

BMI

Do you have:	**Yes**	**No**
Glasses / contact lenses	☐	☐
Dentures / partial / loose teeth / caps	☐	☐
Hearing Aid	☐	☐
Piercings	☐	☐
Other (e.g. prosthesis, wheelchair, cane)	☐	☐

Health History

Please check ☑ all that apply to you

Surgeries (year and where performed):
☐Bowel
☐Abdominal
☐Stomach
☐Heart
☐Lung or chest
☐Gall bladder
☐other_____

Accessories / Devices:
☐artificial heart valve
☐colostomy / ileostomy
☐hip / knee replacement
☐cochlear implant
☐stent (within the past year)
☐other_____
☐ internal cardiac defibrillator

Medical:
☐Diabetes
☐Glaucoma
☐Asthma
☐Heart disease/MI
☐Stroke
☐Rheumatic fever / murmur
☐Kidney disease
☐Liver disease
☐MRSA / VRE
☐ESBL
☐Sleep apnea
☐Seizures
☐COPD
☐Chest pain
☐High blood pressure
☐Rheumatoid arthritis
☐HIV/AIDs
☐Hepatitis A
☐Hepatitis B
☐Hepatitis C
☐Bowel disorder
☐other_____

☐Previous problems with anaesthetics or airway
Have you received Conscious or Moderate Sedation before? Yes ☐ No ☐

Last Menstrual Period: date_____ ☐ Not applicable

Number of pregnancies _____ ☐ Not applicable

Current Medications

(If you have a list from your pharmacy, please attach)
- include pain medication, vitamins, hormone pills, birth control pills, supplements
Medication list attached ☐

Name of the medication	How long have you been on this medication?	How much do you take? (strength and number per day)

Are you taking blood thinners such as Coumadin, Aspirin, Pradaxa? Yes ☐ No ☐
Last dose taken _____ INR_____

How much do you drink each week of:
beer_____ spirits_____ wine_____

Cigarettes / cigars / chewing tobacco: average per day _____

Coffee: average number of cups per day_____

Tea: average number of cups per day_____

Street drugs or recreational drugs: Yes ☐ No ☐
Frequency_____ Type of drug_____

**** A responsible adult MUST escort you home following your procedure.****

Escort Name_____ Telephone _____

Relationship_____ Escort will remain in Waiting Area? Yes ☐ No ☐

Nurse responsible for confirming information provided above:
Print Name_____ Signature _____