EAST VALLEY ENDOSCOPY PATIENT REGISTRATION

PLEASE BRING THE FOLLOWING WITH YOU TO EAST VALLEY ENDOSCOPY AT THE TIME OF YOUR APPOINTMENT:

1. This form, completed, Including a list or copy of your prescribed and over the counter medications, vitamins, & herbal products.
2. Your driver's license or another picture I.D.
3. Your insurance card.

East Valley Endoscopy is not responsible for the loss, disappearance, or damage of personal property or valuables. It is advised not to bring these items with you or you should leave them with your driver.

You are having a planned and elective procedure. In the event of an emergency, we will initiate all resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive or health care power of attorney.

Date of procedure: ______ **Height:** ______ **Weight:** ______
Name: ______ **Age:** ______ **Date of Birth:** ______ **Gender M F**
Address: ______ **City/State:** ______ **Zip Code:** ______
Home telephone number: ______ **Cell Phone Number:** ______
Emergency contact name and number: ______
Responsible person with you: ______
Employer: ______
Work telephone number: ______ **Marital status: S M W D**
Procedure to be performed: Colonoscopy / Flexible Sigmoidoscopy / Esophagogastroduodenoscopy
Doctor performing procedure (circle): Dr. Coates Dr. Figg Dr. Papp Jr. Dr. Serini **Primary care physician:**
Why are you having your procedure done today? ______

HISTORY PER PATIENT ARE YOU BEING OR HAVE YOU BEEN TREATED MEDICALLY OR SURGICALLY FOR:

Condition	No	Yes	COMMENTS
Heart - (Angina, Pacemaker, Stents, Heart Attack, valve, CHF, AICD arrhythmia, afib)	❑	❑	
Hypertension	❑	❑	
Stroke/Tia (mini stroke)	❑	❑	
Lung - (COPD, asthma, TB, Sleep Apnea)	❑	❑	
Kidney (disease)	❑	❑	
Diabetic (oral, insulin, diet) Blood sugar day of procedure ______ time ______	❑	❑	
Endocrine (thyroid, adrenal)	❑	❑	
Liver Disease - (hepatitis cirrhosis varicies)	❑	❑	
Glaucoma	❑	❑	
Seizures	❑	❑	
Muscle disease	❑	❑	
Arthritis	❑	❑	
Sedation/anesthesia problems (Malignant Hypothermia, Resistant, Sensitive, nausia/vomiting)	❑	❑	
Cancer	❑	❑	
Hemorrhoids	❑	❑	
Bleeding tendency	❑	❑	
(Blood thinners)-coumadin, etc.	❑	❑	

Condition	No	Yes	COMMENTS
HIV Testing or Exposure or Diagnosis of contagious diseases (MRSA)	❑	❑	
Pregnancy/Nursing	❑	❑	
Are you trying to get pregnant?	❑	❑	
Think you may be pregnant?	❑	❑	
First day Last Menstrual Period			
Menopausal	❑	❑	
Migraines	❑	❑	
Headaches	❑	❑	
Psychiatric -(depression, anxiety, bipolar, mood disorders, PTSD, dementia)	❑	❑	
Substance use (Include type, amout and when last used) — Smoking (circle if applicable) Tobacco, Vaping, Marijuana	❑	❑	
Alcohol	❑	❑	
Recreational Drugs	❑	❑	
Diarrhea/Constipation/IBS	❑	❑	
Colon Cancer	❑	❑	
Immunosupression	❑	❑	
Colon Polyps	❑	❑	
Colitis/Crohn's Disease	❑	❑	
GERD, Ulcers, Stricture, Barrett's	❑	❑	
Family History Colon Cancer/Colon Polyps	❑	❑	

PLEASE LIST ALL PREVIOUS ILLNESS / SURGERY / HOSPITALIZATION

______

DENTURES: ❑ None ❑ Upper ❑ Lower ❑ Partial **HEARING AID:** ❑ L ❑ R ❑ No **GLASSES / CONTACTS:** ❑ Yes ❑ No

BODY PIERCINGS: ______ **TESTS / IMMUNIZATIONS:** TB skin test ______ Flu ______ Pneumovax ______

CURRENT MEDICATIONS Medication / Dose / Frequency	Taken Today		Taken Today	ALLERGIES	REACTIONS
1.	❑	6.	❑		
2.	❑	7.	❑		
3.	❑	8.	❑		
4.	❑	9.	❑		
5.	❑	❑ See list attached		Latex Y N	

Currently having any pain? No ______ If yes, where? ______ New or chronic? ______

Patient Signature ______ Last food ______ drink ______ prep ______

Reviewed with patient by MD ______ ______ prep RN ______ ______ procedure RN ______ ______
Signature Date Signature Date Signature Date

Patient Questionnaire and HIPAA Acknowledgement

Patient Name: ______________________________ Date: ________________________

Home Tel. (___)____________ Work Tel. (___)____________

Cell Tel. (___)______________

May we contact you at home? **Yes / No** May we contact you at work? **Yes / No**
May we contact you on your cell phone? **Yes / No**

If there is a phone message system may we leave a message for you with our company name and what the call is in reference to at any of the contact numbers you have provided? **Yes / No**

Comment/Except____

Is there anyone we can leave a message with or that you give permission to Gastroenterology Specialists, P.C. and East Valley Endoscopy to release any medical information, unless specified below? **Yes / No** (If yes, please list first and last names)

____

____

____

Exception: (Do not release medical information about)

____

Gastroenterology Specialists P.C./East Valley Endoscopy has a copy of my rights as a patient under the HIPAA act posted (see window at check in) and I have been offered a copy of it. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction.

Patient Signature ______________________________ **Date**________________________

____
Witness

This is form will expire in one year after the date of signature.

Form #122