**Pre-Procedure Patient Information Form-PLEASE COMPLETE BOTH SIDES**

Please carefully complete this form. It is important that we have all of the information we need to assess your current health status. Your information will be reviewed by our Open Access Department, and we will call you after receiving this form to schedule your procedure. Please call 434-817-8484 and choose the Open Access option if you have questions.

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| --- | --- | --- | --- | --- |
| **Name** | **Date of Birth** | **Gender** | **Height** | **Weight**  |

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| **Procedure:**ColonoscopyUpper Endoscopy | **Reason for Procedure:**First time screeningFollow up | **Do you have a history of:****Colon Cancer? ⃝ Yes ⃝ No****Colon Polyps? ⃝ Yes ⃝ No****Barrett’s Esophagus? ⃝Yes ⃝No** | **Do you have a family history of:****Colon Cancer? ⃝ Yes ⃝ No****Colon Polyps? ⃝ Yes ⃝ No****Gastric Cancers? ⃝ Yes ⃝ No****If yes, who?****Unknown family history ⃝** |

**Medical/Surgical History**

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| --- | --- | --- | --- |
| **Anemia** **⃝** Yes ⃝ No | **Asthma** **⃝** Yes ⃝ No | **Sleep apnea ⃝ CPAP ⃝** present ⃝ past | **Do you use home Oxygen? ⃝** YES ⃝ NO |
| **High blood Pressure ⃝** present ⃝ past | **Diabetic ⃝** Yes ⃝ No**Insulin Dependent?** **⃝** Yes ⃝ No | **Seizures** **⃝** present ⃝ past, when? | **Stroke** **⃝** present ⃝ past, when? |
| **COPD/Emphysema** **⃝** Yes ⃝ No | **Congestive Heart Failure** **⃝** present ⃝ past | **Heart attack** **⃝** present ⃝ past, when? | **A-fib** **⃝** present ⃝ past |
| **Organ transplant** **⃝** No **⃝** Yes, describe: | **Kidney disease:** **⃝** present ⃝ past**Are you on dialysis?** **⃝** YES ⃝ No | **Do you have chest pain?** **⃝** Yes ⃝ No**Do you take nitroglycerin?** **⃝** Yes ⃝ No | **Pacemaker or other implantable device?** **⃝** Yes, describe: ⃝ No |
| **Crohn’s** **⃝** present ⃝ past | **Diverticulosis** **⃝** present ⃝ past | **Hepatitis** **⃝** present ⃝ past | **HIV/AIDS** **⃝** YES ⃝ No |
| **Constipation** **⃝** Past ⃝ Present**Concerning?** | **Difficulty Swallowing** **⃝** Past ⃝ Present**Concerning?** | **Reflux/heartburn** **⃝** Past ⃝ Present**Concerning?** | **Are you pregnant or breastfeeding?** **⃝** Yes ⃝ No |
| **Colitis ⃝** present ⃝ past | **MRSA ⃝** present  ⃝ past, when? | **TB ⃝** present ⃝ past | **C Diff ⃝** present ⃝ past |
| **Abdominal pain** **⃝** Past ⃝ Present**Concerning?** | **Do you smoke?** **⃝** Yes, how much? ⃝ past ⃝ No | **Do you drink alcohol?** **⃝** Yes, how much? ⃝ past ⃝ No | **Clotting disorders****⃝** No **⃝** Yes, describe: |

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| **Do you see any Medical Specialists? ⃝ No ⃝ Yes****If yes, list name, reason that you see them, and date of last visit.****Have you EVER seen a cardiologist? ⃝ Yes ⃝ No** | **Do you have any upcoming medical procedures, surgeries, tests, or appointments? ⃝ No ⃝ Yes, describe:** |
| **Are you on any blood thinning medication? ⃝ No ⃝ Yes****If yes, what medication and who prescribes this for you?** | **Can you walk up one flight of stairs without getting short of breath? ⃝ No ⃝ Yes****Do you use any devices to help you walk?** **⃝ No ⃝ Yes, describe:** |

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| **List all previous surgeries/procedures, please include date:** | **Have you ever had problems with anesthesia in past?****⃝ No ⃝ Yes, describe:****Have you ever been told you have a difficult airway?****⃝ No ⃝ Yes, describe:** |
| **Patient Name:** | **Date of Birth:** |
| **Do you have any memory impairment or difficulty in processing instructions, example: dementia, Alzheimer’s, other disability** **⃝ No ⃝ Yes, describe:****Do you have someone that helps you make medical decisions?** **⃝ No ⃝ Yes, name:****Are there any special accommodations that you need in order to make your procedure more comfortable for you?** **⃝ No ⃝ Yes, describe:** | **Preferred Pharmacy Name:****Best number to reach you:****Best time to reach you:**For office use only:

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| --- | --- | --- |
| Level 1 | Level 2 | Level 3 |
| DCC | OA review | APP |
| MJH | Airway √ |  |
| MSC | clearance |  |

**Reviewed by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**MEDICATION LIST**

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| **Medication Name** | **Dosage and Frequency** | **Reason for taking** |
| Example: Nexium | 40 mg, once a day | heartburn |
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**⃝ No Known Medication Allergies**

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| **Allergy**  | **What happens when you are exposed?** |
| Example: penicillin  | Hives, itching |
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**Charlottesville Gastroenterology Associates**

*Patient information for Colonoscopy/Upper Endoscopy*

**You have been referred or recalled for a procedure at CGA. We look forward to assisting you with your scheduling needs.**

**Please complete the patient information form (front and back) demographic sheet and return to our office. We will contact you for a nursing pre-procedure phone-call to schedule your procedure. If indicated, a virtual or in-office visit with our nurse practitioner will be scheduled to complete a pre-anesthesia assessment before scheduling. This is to ensure that you have the safest experience possible.**

* Please complete or update all information requested. Please ensure that we have the best phone number to reach you listed in your chart
* Please sign up for the online patient portal if you are able. This can be beneficial with communication
* We may request notes from specialists you have seen as well as any recent labs/EKG, if needed
* You may be contacted to provide additional information
* You may require additional testing prior to your procedure including bloodwork and EKG
* You may require a visit to another specialist to ensure safety with the anesthesia – these specialists include a cardiologist or your primary care provider
* During the pre-procedure phone call, virtual visit or in-office visit, we will review your information and review your specific prep instructions – including medications, when to stop eating/drinking, and instructions for the day of your procedure
* We ask that you let us know about any changes in your health prior to your procedure
* Please contact us for any questions or concerns about your upcoming procedure

As always, we appreciate you entrusting your gastrointestinal health to us. Our mission is to provide quality, patient-centered medical care for the prevention, diagnosis, and treatment of digestive diseases.

Sincerely,

Charlottesville Gastroenterology Associates

**Please refer to our website** [**www.cvillegi.com**](http://www.cvillegi.com) **for other helpful videos and resources**