CLINICAL ASSESSMENT AND PAST HISTORY

The information collected below is for confidential use by this facility only. Although this information may have been provided to your physician at the office, we do not have access to that information and appreciate your assistance in completing this.

Date: _____
Time: _____
Who is your Primary Care MD?
_____
Is this your first visit here? Y N
What Procedures are you having today?
_____
_____

Please indicate Yes or No to the following questions. All yes answers will be discussed with the Nurse prior to the procedure.

Who will be taking you home today?
This person must wait while the procedure is being performed.
Your procedure will be delayed if your ride leaves the facility.
Name: _____
Phone Number: _____ Relationship: _____
May the Doctor speak to your ride about the results: Yes No

Do you have any Drug Allergies? Y N (if yes, please explain)

(Medications)	(Reactions)
_____	_____
_____	_____
_____	_____

Heart Disease or Heart Problems.....	Y	N
High/Low(Circle One) Blood Pressure Problems ..	Y	N
Asthma/Breathing Problems.....	Y	N
Do you use Inhalers?.....	Y	N
Did you use them today?.....	Y	N
Do you have sleep apnea?.....	Y	N
Any Kidney disease?.....	Y	N
Any Liver disease?.....	Y	N
Are you diabetic?.....	Y	N
Did you take insulin today?.....	Y	N
Any family history of colon cancer?.....	Y	N
Any personal history of colon cancer?.....	Y	N
Do you have any bleeding problems?.....	Y	N
Do you have any pain now?.....	Y	N
If yes, where is your pain?_____	Y	N
Pain Level? (0-10)_____		
Do you have glaucoma/eye disease?.....	Y	N
Any strokes or Neurological problems?.....	Y	N
Do you have seizures or epilepsy?.....	Y	N
Do you have migraines/severe headaches?.....	Y	N
Do you have any back/neck/spine problems?.....	Y	N
Any sudden unexplained weight loss?.....	Y	N
Persistent cough/night sweats?.....	Y	N
Do you have any immune diseases?.....	Y	N
Any skin problems/sores/rashes?.....	Y	N
Any possibility you are pregnant?.....	Y	N
Are you currently breastfeeding?.....	Y	N
Are you currently the victim of abuse?.....	Y	N
Do you want information on services available?...	Y	N
Any personal or family anesthesia problems?.....	Y	N
Do you have an advanced directive?.....	Y	N
Do you have a Pacemaker/Implant?.....	Y	N
Do you have a Card for this Device?.....	Y	N
Do you have dentures?.....	Y	N
Do you have Hearing Aides?.....	Y	N
Do you have Glasses/Contacts?.....	Y	N

Any Previous Surgeries? Y N

If Yes, Please List All Surgeries Below:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(LMP if Applicable)
_____

Do you have any religious or cultural beliefs we need to be aware of Today?
Yes No

Medication and Allergies

Latex Allergy Y N
Height:_____ft_____in Weight_____lbs

Please Enter Email Address and Cell# Below
(This is for For Survey Only, Not Shared)

Cell Phone#_____

Email _____

Do you take Aspirin Regularly? Y N
Last Taken? _____

Do you Take Anti-Inflammatory Meds? Y N
Last Taken? _____

Do you use tobacco? Y N
Do you drink alcohol? Y N
Last Taken? _____

Do you use recreational drugs? Y N
Last Taken? _____

Patient Signature_____

RN Verified Information:_____Time: _____

Patient Label

Corpus Christi Endoscopy Center

an affiliate of SCA

Dear Patient:

We are required by the State of Texas to collect race & ethnicity data from our patients. This data will be used by the State of Texas for health planning projects, including management of state health care delivery and public health programs, efficient administration of healthcare services, continuous improvement in the quality of care provided by hospitals and ambulatory surgery centers, effective procurement of healthcare services, and identification and correction of disparities in healthcare access and outcomes. Individually identifiable patient information is protected and encrypted within the State system.

In addition to information collected at the time when surgery is scheduled, we also need you to select your race and ethnicity:

RACE	ETHNICITY
☐ R1 - American Indian/Eskimo/Aleut	☐ E1 - Hispanic or Latino
☐ R2 - Asian or Native Hawaiian or Pacific Islander	☐ E2 - Not-Hispanic or Latino
☐ R3 - Black or African American	
☐ R4 - White	
☐ R5 - Other Race	

If you have any questions, please contact the Texas Health Care Information Collection Center for Health Statistics at (512) 458-7261.

Thank you very much.

Corpus Christi Endoscopy Center Patient Medication List

THIS IS NOT A PHYSICIAN'S ORDER.

Source of Information: ☐Patient Medication List ☐Patient/Family Recall ☐List from Physician ☐Other

Drug Allergies: ☐None ☐Yes-List Medication(s) and Reactions(s):_____

_____

_____

Other Allergies: Food: ☐No ☐Yes-List with Reaction: _____

Latex: ☐No ☐Yes-Reaction:_____

Medications/Vitamins Over the Counter Supplements	Dose	Route	Frequency	Completed Day of Surgery Date Last Taken

Office Use Only

Pre-Op Med
- ☐ **Versed (sedative)**
- ☐ **Vancomycin (antibiotic)**
- ☐ **Cefazolin/Ancef (antibiotic)**
- ☐ **D5LR (IV fluid)**
- ☐ **0.9% Normal Saline (IV fluid)**
- ☐ **Lidocaine (IV start numbing med)**
- ☐ **Fleet Enema**
- ☐ **Other: _____**

During Procedure
- ☐ **Propofol**
- ☐ **Lidocaine**
- ☐ **Robinul**
- ☐ **Ephedrine Sulfate**
- ☐ **Saline**
- ☐ **Epinephrine**
- ☐ **Spot**
- ☐ **Other: _____**

Recovery Meds
- ☐ **Phenergan (nausea)**
- ☐ **Zofran (nausea)**
- ☐ **Labetalol (blood pressure)**
- ☐ **Morphine (pain medicine)**
- ☐ **Cefazolin/Ancef (antibiotic)**
- ☐ **Resume current home meds**
- ☐ **See Dr's Instructions for Medication restrictions.**
- ☐ **Other:_____**

PRESCRIPTIONS GIVEN TO PATIENT UPON DISCHARGE

Medication Name	Dose	Route	Frequency

_____ _____ _____

Pre-Op Nurse Signature **Circulating Nurse Signature** **Discharge Nurse Signature**

_____

Patient (Responsible Party at Discharge) Signature & Date

Patient Sticker

Screening questionnaire for:

Ebola Virus Disease (EVD), Zika Virus (ZIKA),

check any that apply:

- Have you traveled out of the United States within the past year? ____yes ____no
- Travel to Guinea, Sierra Leone, Liberia, Nigeria, Senegal, Puerto Rico, or the Democratic Republic of Congo? ____yes ____no
- Have you been exposed to anyone who potentially could have been exposed to the Ebola or Zika virus? ____yes ____no
- Have you had a sudden FEVER of ≥ 100.4°F ____yes ____no

PLUS ONE OR MORE:

1. Severe Headache---------- ___yes__no
2. Muscle Pain---------- ___yes__no
3. Diarrhea & Vomiting---------- ___yes__no
4. Abdominal (stomach) pain---------- ___yes__no
5. ***Unexplained*** bleeding or bruising--------- ___yes__no
6. ***Rash or Conjuctivitis***---------- __yes__no

- If necessary, put a mask on the patient and place in Standard Isolation, Contact and Droplet Precaution. Notify Local Department of Public Health (DPH).

Surgical Care Affiliates®

Patient Advisory and Acknowledgment

Receiving Surgical Treatment During the COVID-19 Pandemic

Dear Patient:

While our facility complies with state health department and the Centers for Disease Control and Prevention (CDC) infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees. Our staff, your physician, and your anesthesia personnel are symptom-free.

Since this facility is a provider of healthcare services, persons (including other patients or staff) could be exposed or infected, with or without their knowledge. In order to reduce the risk of spreading COVID-19, we have employed reasonable precautions including preoperative screening of patients and daily screening of healthcare workers.

This information is provided to assist you in making an informed decision regarding the risks and benefits of your scheduled procedure during this time.

By signing below, you are acknowledging your participation in the COVID-19 screening process, the truthfulness of your responses, and that you have discussed COVID-19 related risks with your surgeon.

Thank you for choosing Corpus Christi Endoscopy Center.

Patient Printed Name: _____

Patient Signature: _____

Date: _____

Corpus Christi Endoscopy Center
an affiliate of SCA

PATIENT COMMITMENT

CCEC NEEDS YOUR HELP. A CRITICAL CONVERSATION TO PREVENT FALLS/INJURIES
IS OUR GOAL TO KEEP YOU FREE FROM HARM.

The Ambulatory Surgery Center is very different from what you are used to at home. This may change your ability to get up and around by yourself. Tell me if you feel dizzy, weak, or lightheaded. Always ask for assistance to get out of bed, going to the bathroom, getting out of a chair, and getting dressed!

There are 4 specific things that increase your risk of falling/having an injury.

1. **A**ge
   - 1 out of 3 people over the age of 65 will fall each year.
   - If you are older than 75 and fall, you are more likely to require a rehabilitation, skilled nursing, or long-term care facility.
   - Almost 3 out of 4 people over 85 who fracture a hip die within a year.

2. **B**ones
   - Previous fractures, weak bones, bone cancer, fatigue or weakness, or medicine that causes weak bones make you more likely to be injured from a fall.
   - If you break your hip, you will need surgery that may result in you being placed in a nursing home.

3. **C**oumadin, heparin or any other blood thinners may make you more likely to be injured from a fall. You may have noticed that you bruise easily when taking these medications.
   - If you bump your head during a fall, it could cause bleeding in your brain. This can be very dangerous, and a serious head injury could lead to death.

4. **S**urgery/Procedure
   - Surgery/Procedure can weaken you and can affect your ability to stand or walk by yourself. Even though you may feel safe on your own, anesthesia and pain medications also increase your risk of falling.
   - Your fall risk could continue up to 2 or 3 days and as long as you are taking medication.

   You may keep this information so you can remember the "ABCS" and why it is important for you to call for assistance.
   We are committed to keeping you safe and free from injury, but we need your help!

Patient signature_____ Date _____ Time_____

Nurse signature _____ Date_____ Time_____

☐ Patient verbalizes understanding.