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?
_____
Who is your referring MD?
_____
What procedure(s) are you having today?
_____

Have you had a fever (temp > or = 100.4 F), sore throat, congestion, or runny nose within the last 24 hours? Y N
(**NOT associated with a chronic condition, such as allergies**)

Emergency Contact
Name: _____
Phone Number: _____ Relationship: _____

Height: _____ft _____in **Weight**:_____lbs

Do you have dentures?..... Y N
Do you have Hearing Aides?.....Y N
Do you have Glasses/Contacts?..... Y N
Do you have an advanced directive?.....Y N
Do you have any religious/ cultural beliefs we need to be aware of today?..... Y N

Heart Disease or Heart Problems..... Y N
Have you seen a Cardiologist?..... Y N
Name of Cardiologist_____
Date of last visit_____
Reason for last visit_____
Heart stents Y N History of heart attack Y N
Irregular heart rhythm Y N Heart Murmur Y N
Do you have a Pacemaker/Defibrillator?.....
*If **yes**, please provide your ID Implant Card for this device.*
Blood pressure problems..... Y N
(Circle One) HIGH or LOW
Asthma/breathing problems..... Y N
Do you use supplemental oxygen?..... Y N
Do you use Inhalers?..... Y N
Do you have sleep apnea?..... Y N
Do you use a CPAP or BiPAP?..... Y N
Any kidney disease?..... Y N
Any liver disease?..... Y N
Are you pre-diabetic/diabetic?..... Y N
Any thyroid disorders?..... Y N
Any personal or family history of colon cancer?... Y N
Do you have any bleeding disorders?..... Y N
Do you have glaucoma/eye disease?..... Y N
Any strokes or neurological problems?..... Y N
Have you had any loss of ability to move parts of your body due to stroke?..... 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
Do you have any autoimmune diseases?..... Y N
Any skin problems/sores/rashes?..... Y N
Are you currently the victim of abuse?..... Y N
Do you want information on services available for abuse?..... Y N

Surgical History
Any previous surgeries? Y N
If ***yes***, please list all surgeries below:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Date of last menstrual cycle:
_____

Any possibility you are pregnant? Y N

Are you currently breastfeeding? Y N

Allergies
Do you have any medication allergies? Y N

Name of Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

	Reaction
Latex allergy Y N	_____

Do you have any food allergies? Y N

Name of Food	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Any personal/ family anesthesia problems? Y N
If ***yes***, explain:_____

Do you use tobacco? Y N
Last time smoked? _____

Do you drink alcohol? Y N
How often? (Circle) Rarely Socially Daily
How many drinks per day? _____

Do you use recreational drugs? Y N
If ***yes***, what kind? _____
Last date of use: _____

Patient Signature_____

RN Verified Information:_____Time: _____

Patient Label

Classified as Confidential

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	Reason	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 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

Corpus Christi Endoscopy Center
an affiliate of SCA

PATIENT COMMITMENT

CCEC would like to request your help.

Our ***GOAL*** **is** to keep you **Free From Harm while** ***Respecting your*** **privacy.**

- Before your procedure, if identified as a fall risk, you will be assisted by a Teammate.
- After the procedure, *all patients* are fall risks and will be assisted getting out of bed, getting dressed, to the bathroom if needed and discharged via wheelchair.

We may also utilize a gait belt to better maintain your safety.

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.

Please review the "ABCS" and why it is important for you to call for assistance.

We are committed to keeping you safe and free from harm.

Patient signature_____ Date _____ Time_____

Nurse signature _____ Date_____ Time_____

☐ Patient verbalizes understanding.

FALL RISK ASSESSMENT TOOL

PRECAUCIONES DE RIESGO DE FALL UNIVERSAL implementadas en todos los pacientes.

APPLY A YELLOW HIGH RISK FOR FALLS bracelet if ANY of the following apply:	**Y/N**
Mobility Limitations: ¿Tiene alguna limitación de movilidad donde necesita caminar con un bastonel o un andador o silla de ruedas?	
Patients with use of a cane, walker or any other durable medical equipment. These can be reported or observed.	
Active vertigo or severe dizziness: ¿Tiene mare grave?	
Impaired judgment/mental or emotional status ¿Deterioro del juicio/estado mental o emocional?	
Lack of safety awareness.Falta de concienciación sobre la seguridad	
Sensory deficit: Hearing or vision that affect balance? ¿Déficitsensorial? ¿Audición o visión que afectan el equilibrio?	
History of Falls Frequent or recent falls within 6 month. ¿La historia de las cataratas Cae frecuente o reciente en el plazo de un mes?	
4 or more prescriptions (Blood pressure, psychotropic,& narcotics). 4 o más recetas (Presión arterial, psicotrópicos, y narcóticos)	
Contraindications for use of Gait Belt (circle if applicable) Recent within 6 months. Recent abdominal, chest or back surgery, Recent colostomy/ileostomy surgery, Abdominal Aneurysm, phobia regarding belts and severe cardiac/respiratory condition? ¿Recientes en los últimos seis meses de cirugía abdominal, torácica o de espalda, Cirugía reciente de colostomía/ileostomía, Aneurisma abdominal, fobia a los cinturones y a la condición cardiaca/respiratoria grave?	

Falls Risk precautions initiated for all perioperative procedure patients.

IMPORTANT: All patients will be assisted to dress by teammates. All patients will be accompanied to the restroom by a teammate while in the facility. Explain to the patient that this is for their own safety (patient commitment).

IMPORTANTANTE: Todos los pacientes serán asistidos para vestirse por sus compañeros de equipo. Todos los pacientes serán acompañados al baño por un compañero de equipo mientras están en el centro. Explique al paciente que esto es por su propia seguridad (compromiso del paciente).

Patient Signature **Date** **Time**

Nurse's Initials Date Time

PATIENT LABEL

Revised 07/07/2022