

## 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)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 35%;">Heart Disease or Heart Problems.....</td> <td style="width: 5%;">Y</td> <td style="width: 5%;">N</td> <td style="width: 55%;">Any Previous Surgeries? 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Y	N		<p style="text-align: center;"><b>Medication and Allergies</b></p> <p>Latex Allergy Y N</p> <p>Height: _____ft _____in Weight _____lbs</p> <p style="text-align: center;">(This is for For Survey Only, Not Shared)</p> <p style="text-align: center;">Please Enter Email Address Below</p> <p>Email _____</p> <p>_____</p> <p>Do you take Aspirin Regularly? Y N</p> <p>Last Taken? _____</p> <p>Do you Take Anti-Inflammatory Meds? Y N</p> <p>Last Taken? _____</p> <p>Do you use tobacco? Y N</p> <p>Do you drink alcohol? Y N</p> <p>Last Taken? _____</p> <p>Do you use recreational drugs? Y N</p> <p>Last Taken? _____</p>
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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
<input type="checkbox"/> R1 - American Indian/Eskimo/Aleut	<input type="checkbox"/> E1 - Hispanic or Latino
<input type="checkbox"/> R2 - Asian or Native Hawaiian or Pacific Islander	<input type="checkbox"/> E2 - Not-Hispanic or Latino
<input type="checkbox"/> R3 - Black or African American	<input type="checkbox"/> Prefer not to disclose for personal reasons
<input type="checkbox"/> R4 - White	
<input type="checkbox"/> R5 - Other Race	
<input type="checkbox"/> Prefer not to disclose for personal reasons	

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.







**Screening questionnaire for:**

**Ebola Virus Disease (EVD) and 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  $\geq 100.4^{\circ}\text{F}$  \_\_\_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 Conjunctivitis** \_\_\_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).