120 W. Center Street
W. Bridgewater, MA 02379
508-586-8700

It is mandatory to have a responsible adult driving you home.

It is very important to bring this form to your appointment. If you do not bring it with you it may delay your appointment.

Take a Virtual Tour by going to our website: www.comendoscopy.com

PRE-PROCEDURE ASSESSMENT

PATIENT NAME ______________________ / REASON FOR EXAM ______________________

PRIMARY CARE PHYSICIAN ____

PLEASE MARK THE FOLLOWING APPROPRIATELY: **ALLERGIES:** MEDICATION ❒ YES ❒ NO If yes, explain: ______
LATEX ❒ YES ❒ NO ______________

PERSONAL HISTORY (SELF)	YES	NO	EXPLANATION, IF YES
HEART DISEASE / MURMER / HEART ATTACK			
ANGINA			
HIGH BLOOD PRESSURE			
BLEEDING/CLOTTING PROBLEMS			
BREATHING/LUNG PROBLEMS			
SEIZURES/STROKES/EPILEPSY			
ANEMIA			
LIVER/KIDNEY DISEASE			
HISTORY OF CANCER (SELF)			
DIABETES			
THYROID PROBLEMS			
ARTHRITIS/LIMITATIONS OF MOVEMENT			
IMPLANTED PACEMAKER / DEFIBRILLATOR			
PREGNANT			
DIARRHEA/CONSTIPATION			
TROUBLE SWALLOWING/FOOD STICKING			
SMOKE/DRINK ALCOHOL -- IF YES, AMOUNT			
RECREATIONAL DRUG USE			
PAST SURGICAL HISTORY ______			
OTHER ______			

Have you or any family member experienced problems with anesthesia or sedation? ________ NO ________ YES, EXPLAIN

____

** UNLESS OTHERWISE DIRECTED BY THE DOCTOR, TAKE ALL YOUR MEDICATIONS

**PLEASE REVIEW THE INSTRUCTIONS YOU RECEIVED FROM YOUR DOCTOR'S OFFICE.

**NO IBUPROFEN / ARTHRITIS PRODUCT OR PRODUCTS CONTAINING THESE FOR ONE WEEK PRIOR TO THE PROCEDURE WITHOUT PHYSICIAN APPROVAL.

**DO NOT BRING MONEY OR VALUABLES WITH YOU.

**YOU MUST HAVE A RIDE HOME WITH A RESPONSIBLE ADULT; A TAXI WITH A RESPONSIBLE ADULT (NOT THE TAXI DRIVER) IS ALLOWED.

** IF YOU USE INHALERS, BRING THEM WITH YOU THE DAY OF YOUR PROCEDURE

* PLEASE FILL OUT MEDS ON BACK

Pre Op Nurse Sign: ______________________

Date: ______________________

Commonwealth Endoscopy Center Medication Reconciliation Form

DATE	MEDICATION	DOSAGE	TIMES	LAST DOSE	RESUME MEDICATIONS	COMMENTS

☐ Resume all medications as indicated above

☐ Hold the following medication ____________________ for ____________ days.

☐ New medications have been added today

☐ No new medications have been added.

Copy Received/Signature of patient ______________________________

Nurse Signature: ______________________________

Date: ____________________