

**Ocean Surgical Pavilion**  
**Pre-Procedure History and Physical**

***This section to be completed by patient:***

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Reason for visit \_\_\_\_\_

Referring MD \_\_\_\_\_ Family MD (if different) \_\_\_\_\_

Medications (List ALL medications including: prescriptions, over the counter, vitamins, and herbal medications)

Medication	Frequency	Dose	Medication	Frequency	Dose

List all Allergies and Reactions: \_\_\_\_\_

- Latex Allergy   
  Egg/Chicken Allergy   
  I have had a drug or anesthesia reaction

Medical Problems:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Major Surgery:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***Scheduler use only:***

Relevant Medical Conditions

Cardiac Disease: \_\_\_ CHF \_\_\_ Valve Replacement  
 \_\_\_ Endocarditis \_\_\_ IACD/Pacemaker \_\_\_ Angina  
 Hypertension  
 Liver Disease: \_\_\_ Hepatitis \_\_\_ Cirrhosis  
 Lung Disease: \_\_\_ Home Oxygen  
 Kidney Disease: \_\_\_\_\_

Relevant Medications:

Iron  
 Insulin  
 Oral Hypoglycemics  
 Diuretics  
 Antihypertensives \_\_\_\_\_  
 Coumadin/Plavix  
 < 18 or > 75     > 350 lbs

Special Instructions:

- Continue PPI     Study off PPI

Prep:     OsmoPrep     MoviPrep     Miralax  
 Fleets Enema     2-Day Prep     None

Instruction Packet:  In person     Mailed     Pick-up  
 Emailed     Internet

Demographic information confirmed by: \_\_\_\_\_

Procedure scheduled for: \_\_\_\_\_

***Physician Use Only:***

Procedure:  FGD     Colon     Bravo     FOS  
 PEG     Banding     Lv Bx     Para     EUS     Tattoo  
 EMT     VCE     ERCP     BARRX

Bx:  E     G     D     R     C     I  
 Sprue     Barretts

Location:  OSP     JSMC     MMC

Prior Visit Date: \_\_\_\_\_ MD: \_\_\_\_\_

Prior Procedure Date: \_\_\_\_\_ MD: \_\_\_\_\_

Open Endoscopy?    Y    N

Pre-Procedure Physical	Pt cleared for MAC/Propofol? <input type="checkbox"/> Yes <input type="checkbox"/> No
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ASA Class	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
HT:	WT:

Exam	NL	ABNL
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Mental Status		
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Cardiac		
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Lungs		
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Abdomen		
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Ext		
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Procedure Indications:

- 1
- 2
- 3

Assessing MD Signature \_\_\_\_\_

Date: \_\_\_\_\_

Pt Seen in office by:  FRG     MSS     BT     PST  
 MPA     SD     PG