Sutter Health
Golden Gate Endoscopy Center

G2 ANESTHESIA
SEMPER VIGILANS

BAAM
Bay Area Anesthetic Management

Patient History, Clinical Assessment and Anesthesia Evaluation

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

Name of the person taking you home today: _____

Relationship to you: _____ Phone #: _____

May the Doctor speak to your designated ride home today after your procedure? ☐ Yes / No ☐

Is this person waiting in the center? ☐ Yes / No ☐

Is this person your emergency contact? ☐ Yes / No ☐ If No: please indicate your emergency contact:

Name: _____ Relationship: _____ Phone #: _____

What procedure are you having today? (Please circle) ☐ Colonoscopy ☐ Upper Endoscopy ☐ Sigmoidoscopy

What is the reason for your procedure today: _____

Height: _____ Weight: _____ Primary Care Physician: _____

When did you last eat solid food? Date: _____ Hour: _____ am ☐ /pm ☐

When did you last drink liquid? Date: _____ Hour: _____ am ☐ /pm ☐

HAVE YOU HAD? Circle **YES** or **NO** and **circle the problem** you've had and **explain** if necessary.

Have you experienced a fall within the past year?	Yes	No		
Neurologic disease (e.g., seizures, fainting, stroke)	Yes	No	When / last occurrence?	
Psychiatric illness (e.g., anxiety, panic, depression)	Yes	No		
Heart disease (e.g., chest pain / heart attack, heart failure, coronary artery disease, murmur)	Yes	No	Last visit to cardiologist?	
Arrhythmia (e.g., A-Fib)	Yes	No		
Pacemaker / Do you have your card?	Yes	No	Last visit to cardiologist?	Form ☐
Automatic Implanted Cardiac Defibrillator (AICD), Implantable Cardiac Defibrillator (ICD)	Yes	No		
High or Low Blood Pressure	Yes	No		
High Cholesterol	Yes	No		
Loud snoring, obstructive sleep apnea, CPAP with or without supplemental oxygen	Yes	No		
Lung disease (e.g., emphysema / COPD, asthma, wheezing)	Yes	No		
Are you on home oxygen?	Yes	No		
Recent cough, cold, fever, chills, weight loss, night sweats	Yes	No		
Liver disease (e.g., hepatitis, cirrhosis)	Yes	No		
Kidney disease / Hemodialysis / Peritoneal dialysis	Yes	No		
Bladder or Prostate Disease	Yes	No		
Thyroid disease (e.g., hypothyroidism / hyperthyroidism)	Yes	No		
Diabetes: Type I or Type II. Insulin pump?	Yes	No		
Anemia, abnormal bleeding, abnormal blood clotting	Yes	No		
GI disease (e.g., esophagus, stomach, intestines)	Yes	No		
Migraines, arthritis, chronic pain. Are you currently in pain?	Yes	No	Where?	Pain level (0-10)?
Do you take aspirin or NSAIDs? (e.g., Ibuprofen, Aleve, etc.)	Yes	No	Last taken?	
Personal history of cancer	Yes	No	Diagnosis?	When?
Any Family history of colon cancer	Yes	No	Who?	Age at diagnosis?
Immune disease (e.g., HIV+)	Yes	No		
Autoimmune disease (e.g., Lupus, Rheumatoid Arthritis, etc.)	Yes	No		

Eye disease (e.g., Glaucoma, Cataracts)	Yes	No	
Skin problems, sores, rashes	Yes	No	
Recent or possible pregnancy, breastfeeding	Yes	No	N/A LMP:
Are you currently a victim of abuse and need information	Yes	No	
Any religious / cultural beliefs we need to be aware of	Yes	No	
Advance directive	Yes	No	If yes, where is it on file:
Alcohol use	Yes	No	Drinks per day:
Recreational drug use	Yes	No	
Smoking	Yes	No	Packs per day: Asked to stop prior to day of procedure? Y/N Did you smoke on day of procedure? Y/N
OTHER MEDICAL PROBLEMS:	Yes	No	
PRIOR SURGERIES: . *If Yes, please list type of surgery and the year it was performed.*	Yes	No	
Have you had an endoscopy or colonoscopy before? If Yes, please circle which procedure above & indicate when: _____	Yes	No	
If so, any problems with your sedation?	Yes	No	
Have you ever had any problems with anesthesia?	Yes	No	
Have relatives had problems with anesthesia?	Yes	No	
Can you climb 2 flights of stairs without chest pain or shortness of breath?	Yes	No	

Please list other concerns you would like to discuss with your nurse or doctor: ☐ None

I understand that if a condition arises that my physician feels requires admission to the hospital, he / she may admit me as an in-patient.
**I understand that driving a motorized vehicle less than 24 hours after sedation is prohibited. **
I have arranged for a responsible adult to take me home today.
I have left all valuables at home or in the care of others and hereby release the surgery center from responsibility for the same

Patient Signature: _____ Date:_____ Time:_____

Medical History Reviewed and Discussed with the Patient:

R.N. Signature _____ Date: _____ Time: _____

Anesthesiologist Signature _____ Date: _____ Time: _____