BRING THIS WITH YOU THE DAY OF YOUR PROCEDURE ALONG WITH A COPY OF THE HOME MEDICATION LIST

HIGHLAND HOSPITAL

HIGHLAND ENDOSCOPY CENTER
PREADMISSION
HEALTH SURVEY

HH 10605APC MR

Phone Number: 341-6877 · Fax Number: 341-8453

☒ Outpatient

RR DONNELLEY

Patient Name: _____ Date: _____

Daytime Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ M Male M Female Height ____ (in) Weight ____ (lbs)

Physician: _____ Procedure Date: _____

Type of Procedure: _____ Reason for procedure: _____

Who will be with you and driving you home from the hospital today? Name: _____ Phone # _____

Do you have any allergies to medications, foods, latex products: ☐ Yes ☐ No, If Yes please list:

Allergy/Reaction:

_____
_____
_____
_____

Allergy/Reaction:

_____
_____
_____
_____

MEDICAL HISTORY: Please check (4) if any conditions below have been a problem and circle

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