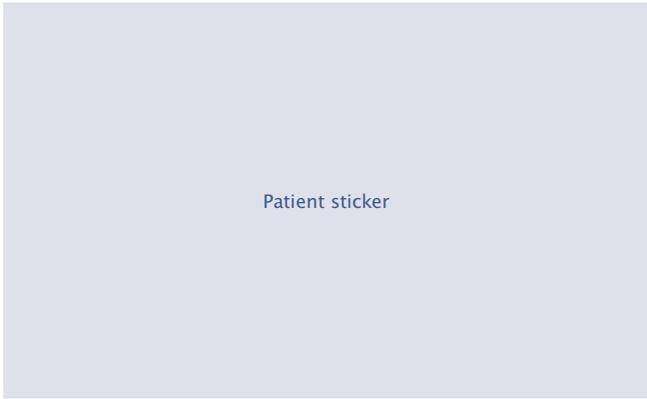


Intake form gastro-duodenum scopy



How long have you had these complaints?

DO YOU HAVE	COMMENT
Weight gain? If yes, how much?	<input type="checkbox"/> yes <input type="checkbox"/> no
Weight loss? If yes, how much?	<input type="checkbox"/> yes <input type="checkbox"/> no
Fever?	<input type="checkbox"/> yes <input type="checkbox"/> no
Difficulty swallowing? The feeling that food won't settle?	<input type="checkbox"/> yes <input type="checkbox"/> no
Chest pain?	<input type="checkbox"/> yes <input type="checkbox"/> no
Gastric acid?	<input type="checkbox"/> yes <input type="checkbox"/> no
Belching/burping?	<input type="checkbox"/> yes <input type="checkbox"/> no
Nausea?	<input type="checkbox"/> yes <input type="checkbox"/> no
Bleeding blood?	<input type="checkbox"/> yes <input type="checkbox"/> no
Stomach ache?	<input type="checkbox"/> yes <input type="checkbox"/> no
Bloating stomach?	<input type="checkbox"/> yes <input type="checkbox"/> no
Heliobacter pylori? If yes, was it treated?	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart complaints?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you visit a cardiologist?	<input type="checkbox"/> yes <input type="checkbox"/> no
Pacemaker/ICD?	<input type="checkbox"/> yes <input type="checkbox"/> no
Lung complaints?	<input type="checkbox"/> yes <input type="checkbox"/> no
Shortness of breath when exercising?	<input type="checkbox"/> yes <input type="checkbox"/> no
Diabetes mellitus?	<input type="checkbox"/> yes <input type="checkbox"/> no
A muscle disorder?	<input type="checkbox"/> yes <input type="checkbox"/> no
Epilepsy?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you use blood thinners?	<input type="checkbox"/> yes <input type="checkbox"/> no
For women: are you pregnant?	<input type="checkbox"/> yes <input type="checkbox"/> no
Are there family members who have intestinal diseases such as bowel infections, colon polyps colorectal cancer, stomach or duodenal ulcers or stomach cancer?	<input type="checkbox"/> yes <input type="checkbox"/> no

USE OF MEDICATION	DOSAGE	USAGE
.....
.....
.....
.....

DELIRIUM> 70 YEAR (ONLY WHEN USED ANESTHESIA)	COMMENT
Do you have memory problems?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you needed help with self-care more than once in the recent past?	<input type="checkbox"/> yes <input type="checkbox"/> no
During prior admissions or illness, were there periods when you were confused?	<input type="checkbox"/> yes <input type="checkbox"/> no

BRMO-MRSA

- Are you BRMO or MRSA positive, or do you have family members who were BRMO/MRSA positive? yes no
- Were you recently (= <2 months ago) admitted to a foreign hospital? yes no
- If yes: Was this for longer than 24 hours? yes no
 - If your stay was shorter than 24 hours, did you undergo surgery or receive a drain or in-dwelling catheter? yes no
 - Do you still have skin lesions or abscesses related to the treatment in the foreign hospital? yes no
- Do you work with live pigs, pork meat or broiler chickens? yes no
- Were you in a care facility that had an outbreak of BRMO/MRSA within the past 2 months? yes no

RELEVANT PRIOR HISTORY/SURGERY

EERDERE SCOPIEËN	JAAR	RESULT
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Allergies: yes no _____

Intoxications:

smoking: yes no alcohol: yes no drugs: yes no

PHYSICAL EXAMINATION (ONLY WHEN USED ANESTHESIA)

Blood pressure: _____ Pulse: _____ Weight: _____

Height: _____ BMI: _____ ASA: _____

RELEVANT COMPAINTS/PARTICULARS

Informed consent:

- | | | |
|---|--|--|
| <input type="checkbox"/> Discussed on _____ | <input type="checkbox"/> Date of intake _____ | <input type="checkbox"/> Date of endoscopy _____ |
| <input type="checkbox"/> Indication/alternatives | <input type="checkbox"/> Procedure/explanation | <input type="checkbox"/> Complications |
| <input type="checkbox"/> Does patient understand the information? | <input type="checkbox"/> Patient given brochures | <input type="checkbox"/> Consent given |
| <input type="checkbox"/> TOP done | <input type="checkbox"/> Sedative <input type="checkbox"/> No sedative | <input type="checkbox"/> If sedative given, transport arranged |

Gastroenterologist/physician's signature: Patient's signature: Nurse's signature:
