# HEALTH QUESTIONNAIRE

**Please complete the details below and submit it to the reception desk.**

## Personal Information

| First name (Given name) | Middle name | Last Name (Family name) |
|---|---|---|
| Nationality | Date of Birth (mm/dd/yyyy) | Gender M ☐ F ☐ |

| | |
|---|---|
| Passport Number | |
| Resident Registration Number (ID No.) | |
| Company / Department | |
| Employee ☐ Family ☐ | **For women** |
| Tel. (Cell phone) | The examination today includes radiologcial test that could harm your fetus. |
| Tel. (Home) | 1. Are you married? Y☐ N☐ |
| Preferred mode of result collection ☐ visit ☐ mail ☐ e-mail | 2. Do you have possibility to be pregnant? Y☐ N☐ |
| E-mail | 3. Are you doing breast-feeding? Y☐ N☐ |
| | 4. Do you consent for radiological exam? Y☐ N☐ |
| Current address | 5. When did your last period start? _____ (mm/ dd / yyyy) |

※ For the benficiaries of health check up program by National Health Insurance Corporation:
Do you agree to be charged by this hospital? ☐ Yes ☐ No Name: _____ (Signature)

## Consent for the Collection and use personal Information

1. Korea Medical Foundation shall collect and use your personal information for the purpose of providing;
   a) Health screening b) Service including follow-up care and referral (eg. SMS, e-mail service)
   c) Membership service (eg. appointments)
   d) Information under relevant law such as Medical Service Act.
2. Range of information collected : Name, resident registration number, address, phone number (home and mobile), e-mail, company name, department, position, and medical results
3. The length information use and possession : 10 years
4. Your personal information will be solely used under the "Personal Information Protection Act" within the scope of confidentiality as a "Medical Law". It will never be used for other purposes, or will be provided to other facilities. (But, when you receive dental care in Lee's Fresh Dental Clinic which cooperates with Korea Medical Foundation, only limited information for an appointment will be shared.)
5. Personal information shall be shared within Korea Medical Foundation for purposes including appointments, treatment, after-service, consultation, and billing.

**I hereby consent to collection and use of my personal information as above.**

Date: (mm/dd/yyyy)

Name: (Signature)

# INSTRUCTIONS FOR HEALTH EXAMINATION

| General Instructions for check up |
|---|
| 1. Have a light dinner the day before check up and fast after 9pm.<br>2. Avoid drinking, smoking and fatigue. Sleep adequately.<br>3. Do not have breakfast including water, gum, cigarette, and juice in the morning of the examination day.<br>4. For accurate examination, those who are scheduled for prostate/pelvis ultrasound examination come to the hospital holding urine after the first urine in the morning.<br>5. Medications for hypertension, thyroid conditions, and heart conditions are permitted with a minimum amount of water in the early morning of examination day.<br>6. If you are scheduled for UGI (Upper gastrointestinal series), medications intake is allowed after check up has been completed.<br>7. If you are taking medications for diabetes, please take the medication after the check up has been completed.<br>8. If you are scheduled for sedation endoscopy, please use public transportation since you won't be able to drive afterwards.<br>9. Do not carry any valuables, and refrain from bring children.<br>10. If you are under treatment or taking medication for any medical or physical condition, please consult a physician in advance.<br>11. If you have dentures or shaking teeth, this could interfere with stomach endoscopy. |
| **Instructions for Female** |
| 1. Please receive the health checkup between 5-15 days after your period.<br>2. If you could be pregnant or if you are breastfeeding, please consult a physician before the examination. |
| **Instructions for Pelvic ultrasound (Prostate / Uterus & Ovaries Ultrasound)** |
| 1. Do not void prior to the ultrasound examination. The test requires a full bladder for best results. |

| Instructions for a stool sample | Directions to collect a stool sample |
|---|---|
| 1. Bring stool sample on the day of examination.<br>2. Store the collected stool sample in a cool place.<br>3. If you are on period, please make sure that the blood does not get mixed with your stool sample. | 1. Twist the green lid to open the container.<br>2. In order to get the stool sample, swipe the stool with the stick attached to the lid, or put the stick inside of the stool.<br>3. Put the stick inside the container, close the lid, and shake the container vertically several times.<br>4. Place the container in a plastic bag, and bring it on the day of examination. |

# Health checkup questionnaire

※ Examinees must complete the questionnaire to receive the results of the cardiovascular disease risk assessment.

| | | | | | | |
|---|---|---|---|---|---|---|
| Last Name | | Resident Reg. No.. | | Telephone | Home | |
| Given Name | | | | | Mobile phone | |
| Current address | | | | E-mail | | |
| | | | | How to receive a health checkup report | □ Post □ E-mail | |

※ Please answer all the questions below.

## Medical history (disease history, family history)

**1.** Have you ever been diagnosed by a doctor with any of the following diseases or are you currently taking any medication?

| | Diagnosis | | Medication therapy | |
|---|---|---|---|---|
| Brain stroke (paralysis) | Yes | No | Yes | No |
| Cardiac infarction/angina | Yes | No | Yes | No |
| High blood pressure | Yes | No | Yes | No |
| Diabetes | Yes | No | Yes | No |
| Dyslipidemia | Yes | No | Yes | No |
| Tuberculosis | Yes | No | Yes | No |
| Others (including cancer) | Yes | No | Yes | No |

**2.** Has anyone in your family died from or gotten any of the following diseases?

| | | |
|---|---|---|
| Brain stroke (paralysis) | Yes | No |
| Cardiac infarction/angina | Yes | No |
| High blood pressure | Yes | No |
| Diabetes | Yes | No |
| Others (including cancer) | Yes | No |

**3.** Are you a Hepatitis B virus antigen carrier?

① Yes ② No ③ No idea

## Smoking and e-cigarettes (vaping)

**4.** Have you ever smoked more than 5 packs of cigarettes (100 cigarettes) in your lifetime?

① No. (☞ Go to Question 5)
② Yes. (☞ Go to Question 4-1)

**4-1.** Do you smoke cigarettes now?

| | | | |
|---|---|---|---|
| ① I do | A total of ____ years | An average of _____ cigarettes a day | |
| ② I used to but not anymore | A total of ____ years | Used to smoke _____ cigarettes a day on average | ____ years since I quitted |

**5.** Have you ever smoked an electronic cigarette (e.g., IQOS, Glo, or Lil)?

① No. (☞ Go to Question 6)
② Yes. (☞ Go to Question 5-1)

**5-1.** Do you smoke electronic cigarettes now?

| | | | |
|---|---|---|---|
| ① I do | A total of ____ years | An average of _____ cigarettes a day | |
| ② I used to but not anymore | A total of ____ years | Used to smoke _____ cigarettes a day on average | ____ years since I quitted |

**6. Have you ever used a liquid electronic cigarette?**

① No.
② Yes. (☞ Go to Question 6-1)

**6-1. Have you used a liquid electronic cigarette in the last month?**

① No ② 1 to 2 days per month ③ 3 to 9 days per month
④ 10 to 29 days per month ⑤ Every day

## Drinking

※ In the past one year

**7.** How often do you have drinks containing alcohol? (Select one)

① ( ) times per week ② ( ) times per month
③ ( ) times per year
④ I don't drink alcohol.

**7-1.** How many drinks containing alcohol do you have on a typical day when you are drinking?

* Choose one among the glass, bottle, can, or cc (you can choose more than one for liquor types; choose a similar type for other liquor types that are not indicated)

| Type of liquor | Glass | Bottle | Can | cc |
|---|---|---|---|---|
| Soju | | | | |
| Beer | | | | |
| Hard liquor | | | | |
| Makgeolli (rice wine) | | | | |
| Wine | | | | |

**7-2.** What is the largest amount of drinks containing alcohol that you have ever had in one day?

* Choose one among the glass, bottle, can, or cc (you can choose more than one for liquor types, choose a similar type for other liquor types that are not indicated)

| Type of liquor | Glass | Bottle | Can | cc |
|---|---|---|---|---|
| Soju | | | | |
| Beer | | | | |
| Hard liquor | | | | |
| Makgeolli (rice wine) | | | | |
| Wine | | | | |

## Exercising

**8-1.** How often do you do high intensity exercise (making you short of breath) per week?

( ) days per week

* Examples of high intensity exercise> Running, aerobics, fast bicycling, construction labor, carrying items using stairs, etc.

**8-2.** How long do you do high intensity exercise (making you short of breath) per day?

( ) hours ( ) minutes per day

**9-1.** How often do you do moderate intensity exercise (making you slightly short of breath) per week?

( ) days per week

* Exclude exercise you have already written in Question 8
* Examples of moderate intensity exercise> Power walking, doubles tennis games, cycling at normal speed, carrying light items, cleaning, etc.

**9-2.** How long do you do moderate intensity exercise (making you slightly short of breath) per day?

( ) hours ( ) minutes per day

**10.** How many days did you do weight training such as push-ups, sit-ups, dumbbell exercises, weight lifting, or horizontal bar exercise in the last one week?

( ) days per week

# Additional health checkup questionnaires

| Last Name | | Resident Reg. No. | |
|---|---|---|---|
| Given Name | | | |

※ Please fill out this questionnaire if it is applicable to you.

## Functional assessment of elderly **(66, 70, and 80 years of age)**

**1.** Do you receive inoculations with influenza vaccine every year?
① Yes ② No

**2.** Have you received vaccinations against pneumonia?
① Yes ② No

**3.** The following questions are about your ability to perform activities of daily living
Please read and answer the questions below.

**1)** If someone sets the table for your meal, you can eat by yourself without any help.
① Yes ② No

**2)** Can you put on your clothes without any help?
① Yes ② No

**3)** Can you go to the toilet by yourself?
① Yes ② No

**4)** When you take a bath or a shower, can you wash by yourself?
① Yes ② No

**5)** Can you prepare your meals?
① Yes ② No

**6)** Can you go to places that are of walking distance, such as a store, clinic, neighbor, or any public offices, by yourself?
① Yes ② No

**4.** About fall injury: Have you fell down during the last 6 months?
① Yes ② No

**5.** Urinary function: Do you have any difficulty in urinating or in holding your urine?
① Yes ② No

# Consent to the utilization of health checkup result for follow-up management

**The purpose of this consent form is to gain agreement for providing the following checkup information for follow-up management according to the checkup results.**
**Please tick '√' for the type of examination you consent to provide information for.**

**[ ] General health examination (including medical benefit life transition period examination)**

- In order to provide health management services* to those who are suspected of having or suffering from high blood pressure, diabetes, dyslipidemia, etc. as a result of general health examinations, the National Health Insurance Service (hereinafter referred to as the "NHIS") shall provide the relevant data to the public health centers. Such public health centers shall provide health care service details to the NHIS.
  * Health management services: Health consultation/education/quit smoking/sobriety/exercise/nutrition, etc.
- The NHIS shall provide the relevant examination data to the Korea Centers for Disease Control and Prevention and public health centers for follow-up management of individuals suspected or diagnosed with pulmonary tuberculosis as a result of general health examinations.
- The NHIS shall provide health centers and dementia relief centers (including central and metropolitan areas) with relevant examination data for post-management of individuals determined to have cognitive decline as a result of cognitive dysfunction test results.

**[ ] Cancer examination**

- The NHIS shall provide the relevant examination data to public health centers and the National Cancer Center for post-management of individuals with abnormal findings, "suspicion of cancer" or "cancer" as a result of cancer examination.

**[ ] Infant health examination**

- The NHIS shall provide the data on the results of developmental evaluations to public health centers in order to support the cost of detailed developmental examinations for infants and young children who have been recommended for "advanced evaluation" as a result of the developmental evaluation of infant health examinations.

※ Your personal information and unique identification information (resident registration number) are subject to Articles 23 and 24 of the 「Personal Information Protection Act」, Articles 18 and 19 of the Enforcement Decree of the same Act, and Article 13 of the Enforcement Decree of the 「Framework Act on Health Examination」, and Article 81 of the 「National Health Insurance Act」 and other relevant laws. Such information shall not be used for purposes other than the intended purpose or provided to other organizations.
※ If you would like to withdraw your consent, it can be withdrawn through a simple verification procedure as you call to the NHIS Customer Service (1577-1000) or its district branch.

## 1. Agreement for provision of personal information

○ I have been sufficiently informed of the terms below in which my personal information will be provided to the public health center and the NHIS and consent to provide related details that I have been notified of.

① **Institutions providing information: Public Health Center, NCC, KCDA, NHIS, Center for Dementia**

② Purposes of providing personal information: To provide healthcare services to those who require self-management and preventive measures and those who have a disease (and suspected of having a disease), to provide post-management based on the cancer screening result, pulmonary TB-related post-management, and **follow-up in accordance to the results of infant development evaluation.**

③ Personal information willing to provide

- **(General examination results)** NHIS → Public health center
  • Personal identification information, such as name, resident registration number, address, telephone number, e-mail, etc., general examination results and questionnaire data
- **(Chest radiograph results)** → KDCA and/or public health center
  • Personal identification information, such as name, resident registration number, address, telephone number, e-mail, etc., chest radiograph results and pulmonary TB-related questionnaire data
- **(Health care services details)** Public Health center → NHIS
  • Personal identification information, such as name, resident registration number, address, and details of health care services provided by the public health center
- **(Cognitive dysfunction test results)** NHIS → Public Health Center and Center for Dementia (including SMCD and NID)
  • Personal identification information, such as name, resident registration number, address, telephone number, e-mail, etc., cognitive dysfunction test results and related questionnaire data
- **(Cancer examination results)** NHIS → Public Health Center and NCC
  • Personal identification information, such as name, resident registration number, address, telephone number, e-mail, etc., cancer examination results and related questionnaire data
- **(Infant health examination developmental assessment result)** NHIS → Public health center
  • Personal identification information such as name, resident registration number, address, phone number, e-mail, and infant health examination development evaluation results, and related diagnosis data

④ Period of retaining and utilizing personal information: 2 years

⑤ You have the right to refuse to agree to provide personal information to the third party, and in this case, you might be excluded as a subject who is offered with health management service of a public health center.

I consent to the terms. ☐ Disagree ☐

**2. Sensitive information**

○ I was notified by the health checkup institution on personal information processing, and with this, they sufficiently explained that my health checkup information and health management service history of the public health center are sensitive information. Therefore, I fully understand and consent to the terms.

I consent to the terms. ☐ Disagree ☐

**3. Consent to the process of identification information**

○ I was notified by the health checkup institution on personal information processing, and with this, they sufficiently explained that the resident registration number is an identification number. Therefore, I fully understand and consent to the terms.

I consent to the terms. ☐ Disagree ☐

**I consent to the terms.** ☐

Year Month Day

| | | | | |
|---|---|---|---|---|
| Consent | Subject name | (Signature) | Resident registration number | - |
| | (In case of infants) Name of legal representative | (Signature) | Relationship to the subject | |
| Name of health checkup institution (Number) | | | | |

# Evaluation of Cognitive Function Difficulty

## Korean Dementia Screening Questionnaire – C

**This questionnaire is for cognitive function difficulty. Please answer the following questions about your present condition compared to last year by ticking the appropriate box below. (This form should be completed by a guardian if the person in question cannot do so.)**

| Korean Dementia Screening Questionnaire - C | No (0 points) | Sometimes (1 point) | Almost every day (2 points) |
|---|---|---|---|
| 1. I (He/She) do (does) not know what the day is today | | | |
| 2. I (He/She) cannot find my own things. | | | |
| 3. I (He/She) ask (asks) the same question over and over. | | | |
| 4. I (He/She) forget (forgets) appointments. | | | |
| 5. I (He/She) placed an object and I am (he/she is) not able to recall where the object is placed. | | | |
| 6. I (He/She) cannot recall people's name or objects' name and has difficult time to say the name. | | | |
| 7. I (He/She) do (does) not (understand conversations and I (he/she) ask (asks) someone about the conversation over and over. | | | |
| 8. I (He/She) have (has) gotten lost in the middle of the road. | | | |
| 9. I've (He/She has) lost the ability to calculate compared to last year. (example: I (he/she) cannot calculate the change or price) | | | |
| 10. My (His/Her) personality has changed a lot. | | | |
| 11. I (He/She) am (is) losing my (his/her) ability to use machinery. (washing machine, electric appliance, tracker, etc.) | | | |
| 12. I (He/She) cannot organize things around the house. | | | |
| 13. I (He/She) cannot choose the right clothes for the right occasion. | | | |
| 14. I (He/She) cannot get to the destination alone by public transportation. (except in cases of physical difficulties, such as knee arthritis.) | | | |
| 15. I (He/She) do (does) not want to change clothes even when they are dirty. | | | |
| Score | | / 30 | |

# Mental Health (Depression) Assessment Tool

## Patient Health Questionnaire-9: PHQ-9

**The purpose of this questionnaire is to assess your level of depression. Although the questions are not for an exact diagnosis, it is very likely that you have depression if you receive high points. In such a case, we recommend that you see a psychiatrist for further evaluation.**

**How often have you suffered from the following symptoms over the past two weeks?**

| | Not at all | For a few days | For over a week | Almost every day |
|---|---|---|---|---|
| 1. I am barely interested in my work. | 0 | 1 | 2 | 3 |
| 2. I feel melancholy, depressed, or hopeless. | 0 | 1 | 2 | 3 |
| 3. It is hard to fall asleep or I wake up very often during the night, or I sleep too much. | 0 | 1 | 2 | 3 |
| 4. I feel exhausted or have no energy. | 0 | 1 | 2 | 3 |
| 5. I have low appetite or eat too much. | 0 | 1 | 2 | 3 |
| 6. I think that I am a bad person or a failure, or I feel like my family is unhappy because of me. | 0 | 1 | 2 | 3 |
| 7. I cannot concentrate when I read a newspaper or watch TV. | 0 | 1 | 2 | 3 |
| 8. I move or talk too slowly to the point that other people can notice it, or I wander or pace around too much because I feel anxious and restless. | 0 | 1 | 2 | 3 |
| 9. I think I am better off dying, or I want to hurt myself in some way. | 0 | 1 | 2 | 3 |
| Points | / 27 | | | |

# National Cancer Screening Program

| | | | | | | |
|---|---|---|---|---|---|---|
| Last Name | | Resident Reg. No. | | Telephone | Home | |
| Given Name | | | | | Mobile phone | |
| ☐ Health insurance ☐ Medicaid recipient | | | E-mail | | | |
| | | | How to Receive the Health Examination Result Report | | ☐ Mail ☐ Email | |
| Current address | | | | | Postal code | |
| | | | | | - | |

※ These are questions about cancer.

※ Please answer the following questions about your **present condition** by ticking the appropriate box.

1. Do you have **any uncomfortable** areas in your body? Where?
   ① Yes (symptom: ) ② No

2. In the **last 6 months**, have you **experienced a weight decrease over 5 kg** without any specific reason?
   ① No ② Yes; total weight loss ( kg)

3. Do you have any family members, including yourself, who have cancer?

| Type of cancer | No | No Idea | Yes (You may select multiple diseases) | | | | |
|---|---|---|---|---|---|---|---|
| | | | You | Parents | Brother | Sister | Kids |
| Gastric Cancer | | | | | | | |
| Breast Cancer | | | | | | | |
| Colon and Rectal Cancer | | | | | | | |
| Hepatoma | | | | | | | |
| Cervical Cancer | | | | | | | |
| Lung Cancer | | | | | | | |
| Others ( ) | | | | | | | |

4. Have you ever undergone **these examinations** before?

| Examination | | Period | | | |
|---|---|---|---|---|---|
| | | Over 10 years ago or none | Within 1 year | Between 1 and 2 years | Between 2 and 10 years |
| **Gastric Cancer** | Photography | | | | |
| | Endoscopy | | | | |
| **Breast Cancer** | Mammogram | | | | |
| **Colon and Rectal Cancer** | Fecal Occult Blood (Stool Test) | | | | |
| | Barium Enema | | | | |
| | Endoscopy | | | | |
| **Cervical Cancer** | Cervical Skin Exam | | | | |
| **Lung Cancer** | Chest CT | | | | |
| **Hepatoma** | Liver Ultrasound | None | Within 6 months | Between 6 and 12 months | Over more than 1 year |
| | | | | | |

※ These are questions only about gastric cancer, hepatoma, and colon and rectal cancer.

※ Please mark 'O' that **corresponds to your condition**.

5. Have you ever been diagnosed with any **stomach disease**?

| Disease | Gastric ulcer | Gastritis | Duodenal ulcer | Polyps | Others (write) | None |
|---|---|---|---|---|---|---|
| Yes | | | | | | |

6. Have you ever been diagnosed with any **colon disease**?

| Disease | Colon polyps | Ulcerative colitis | Crohn's disease | Hemorrhoids | Others (write) | None |
|---|---|---|---|---|---|---|
| Yes | | | | | | |

7. Have you ever been diagnosed with any **liver disease**?

| Disease | Hepatitis B carrier | Hepatitis B | Hepatitis C | Cirrhosis | Others (write) | None |
|---|---|---|---|---|---|---|
| Yes | | | | | | |

8. Have you ever been diagnosed with any **lung disease**?

| Disease | Chronic obstructive pulmonary disease (COPD) (chronic bronchitis, emphysema, etc.) | Pulmonary tuberculosis (TB) | Pulmonary nodules | Interstitial lung disease (ILD) | Pneumo-coniosis | Others (write) | None |
|---|---|---|---|---|---|---|---|
| Yes | | | | | | | |

※ These are questions only about breast cancer and cervical cancer. (For women only.)

9. When was your first menstrual period?
   ① Age: _____ ② I have not gotten my period yet.

10. Do you still experience menstrual periods?
    ① Yes ② I have removed my cervix or uterus.
    ③ Menopause (age: _____)

11. Have you ever taken any medication or hormonal treatment to relieve any menopausal symptoms?
    ① Never ② Yes; for less than 2 years
    ③ Yes; for a period between 2 and 5 years ④ Yes; for more than 5 years ⑤ No idea

12. How many children do you have?
    ① 1 ② More than 2 ③ No child

13. How long did you breast-feed your child?
    ① Less than 6 months ② Between 6 and 12 months ③ More than 1 year ④ Not applicable

14. Have you been diagnosed with a **benign** tumor?
    (Benign tumor is only a tumor; it is **not cancer,** and it is **not even cancerous**.)
    ① Yes ② No ③ No idea

15. Have you taken any birth control pills?
    ① Never ② Less than 1 year
    ③ Over 1 year ④ No idea

# CONSENT FOR STOMACH ENDOSCOPY

| | |
|---|---|
| **Purpose of Examination** | The examination is to diagnose any possible abnormalities in esophagus, stomach, and duodenum, such as any inflammations, ulcers, polyps and cancer. |
| **Cautions** | 1) Please make sure that you have to fast more than 8 hours before examination.<br>2) Any gastrointestinal medications, diabetes medications, and insulin shots are prohibited before the examination.<br>3) Take medications for hypertension 4 hours before the examination.<br>4) Please take off denture before the procedure. |
| **Possible Complications** | You might have some abdominal pain and bloating after the examination. Rarely, a fever, sepsis, bleeding, perforation, dyspnea, hypotension, arrhythmia, and shocks can occur. |

| Cases which require cautions during endoscopy (Answer correctly) | Yes | No |
|---|---|---|
| Hypersensitiveness to medications or food (Antibiotic, anesthetic, egg, bean, sulfites, sulfonamide) | | |
| Cardiovascular diseases (Angina pectoris, myocardial infection, arrhythmia) | | |
| Kidney diseases (Chronic glomerulonephritis, renal failure) | | |
| Liver diseases (Chronic hepatitis, alcoholic hepatitis, hepatic cirrhosis) | | |
| Respiratory diseases (Sleep apnea, asthma, chronic obstructive pulmonary disease, severe snoring, a cold) | | |
| Benign prostatic hyperplasia | | |
| Glaucoma | | |
| Hypertension | | |
| Diabetes | | |
| Thyroid diseases | | |
| Anticoagulant medications (Aspirin, Wafarin, Clopidogrel) | | |
| Chin joining abnormality (Malocclusion, trismus, small jaw) | | |
| Neck abnormality (Cervical herniated disc, rheumatoid arthritis) | | |
| Oral abnormality (Shaking teeth, tonsillar hypertrophy, dental implant) | | |
| Denture | | |
| Pregnancy / Possibility to pregnancy / Breast feeding | | |

| | |
|---|---|
| **Stomach Endoscopy History** | |
| **Surgery History (e.g. abdominal surgery)** | |

During the examination, a biopsy and any additional test might be needed for an accurate diagnosis. It will incur additional costs.

I have been fully informed about the necessity, nature, possible complications of the stomach endoscopy, and I fully understand there are risks of a complication beyond human control or any unexpected accidents caused by idiosyncrasy. I hereby consent to performing the stomach endoscopy.

**Date:** (mm/dd/yyyy)

**Name of Examinee:** (Signature)

**Relationship to the examinee:**

**Name of Parent/Guardian:** (Signature)

# CONSENT FOR CONSCIOUS SEDATION ENDOSCOPY

| | |
|---|---|
| **Purpose of Examination** | The purpose of conscious sedation is to facilitate the performance of endoscopies. By helping a patient relax during the procedure, there are advantages that it alleviates a patient's anxiety and pain and leads to his or her cooperation safely during endoscopy. It is not an anesthesia, and therefore a patient could respond to the medical personnel. |
| **Method** | This method is a technique to reduce the level of a patient's alertness through intravenous injection of sedatives or sleep-inducing medication. However, a patient might wake up during the endoscopic procedure or experience some pain since this method is not an anesthesia. |
| **Cautions** | Please make sure you should fast more than 8 hours before the test. If you have any respiratory, renal, liver, and heart diseases, extra cautions will be required and please consult a physician prior to the examination about your conditions. If you are currently getting treated for shaking teeth, a denture, or temporary teeth, we recommend endoscopy without sedation. |
| **Possible Complications** | Most people get into the sedative state without experiencing much problem, but some people might experience complications such as dyspnea, hypoxia, hypotension, tachycardia. Dizziness, allergic reaction, and local vasculitis by the injection for sedative, nausea, vomiting can occur. These usually settle down with appropriate treatment. Vary rarely, an emergency treatment such as an insertion of artificial airway might be necessary to secure the patient's breath. |
| **Cautions after consicous sedation** | Please make sure to rest on the day of the examination for your complete recovery. You should not drive on the day of the examination, and please avoid any important appointment or tasks. |

Patients should be aware of the information provided above. Please make sure that a patient is liable for problems caused by his or her decision **(e.g. a car accident happened while a patient who received conscious sedation endoscopy drives a car by him or herself )**

I have been fully informed of the necessity, nature, possible complications of the conscious sedation, and I fully understand risks of a complication beyond human control or any unexpected accidents caused by allergies. I hereby consent to the performance of conscious sedation endoscopy.

**Date:** **(mm/dd/yyyy)**

**Name of Examinee:** **(Signature)**

**Relationship to the examinee:**

**Name of Parent/Guardian:** **(Signature)**