

Endoscopy/Medical Procedure Center  
Preprocedure Medical History Form

FOR REGISTRATION PURPOSES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ Social Security # \_\_\_\_\_

\_\_\_\_\_ Phone Number: \_\_\_\_\_

Marital status: never married / married / widowed / living as married / separated / divorced

Employment status: full time part time retired self-employed unemployed active military

Employer: \_\_\_\_\_ Religion: \_\_\_\_\_

INSURANCE INFORMATION:

TYPE OF INSURANCE #1 \_\_\_\_\_ POLICY # \_\_\_\_\_

If you are not the subscriber, please provide us with the following information:

SUBSCRIBER NAME: \_\_\_\_\_ SUBSCRIBER BIRTHDATE: \_\_\_\_\_

SUBSCRIBER SOCIAL SECURITY #: \_\_\_\_\_

Employment status: full time part time retired self-employed unemployed active military

Employer: \_\_\_\_\_

TYPE OF INSURANCE #2 \_\_\_\_\_ POLICY # \_\_\_\_\_

If you are not the subscriber, please provide us with the following information:

SUBSCRIBER NAME: \_\_\_\_\_ SUBSCRIBER BIRTHDATE: \_\_\_\_\_

SUBSCRIBER SOCIAL SECURITY #: \_\_\_\_\_

Employment status: full time part time retired self-employed unemployed active military

Employer: \_\_\_\_\_

If one of your insurances is Medicare please answer the following questions:

Do you receive Black Lung Benefits?  Yes  No

Do you take part in any research programs?  Yes  No

Is your procedure being covered by the Department of Veteran Affairs (DVA)?  Yes  No

Are you here due to an injury?  Yes  No

Did you receive your Medicare due to your age, a disability, or ESRD? \_\_\_\_\_

Are you currently employed?  Yes  No

If you are not employed, when was the last time you held a paying position? \_\_\_\_/\_\_\_\_/\_\_\_\_

If you are married, is your spouse currently employed?  Yes  No

If your spouse is not employed, when was the last time he/she held a paying position? \_\_\_\_/\_\_\_\_/\_\_\_\_

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Name \_\_\_\_\_

**ON THE DAY OF YOUR PROCEDURE:**

- Complete this form and bring it with you
- Bring your insurance card / co-payment with you if required
- If you have a Health Care Proxy please bring a copy with you.
- Arrive at specified time
- If you are being sedated, you must have a responsible adult to drive you home and stay with you for the rest of the day, **or your procedure will be cancelled.**
- Drivers name and phone number \_\_\_\_\_
- Please instruct your driver to come up to our department to receive discharge instructions and escort you to the car.
- You may take a taxi if you have a responsible adult to escort you. **We do not consider the taxi driver your escort.**
- Taking a bus home is not acceptable.
- Please bring an interpreter with you if you do not understand English.
- Let your Doctor know if you have a pacemaker or cardiac defibrillator.

Do you have any **ALLERGIES** to any **MEDICATIONS**? Please list:

DRUG

REACTION


**Latex Screening:**

Do you have an allergy to latex or rubber products?  Yes  No  
 If yes, what is the reaction? \_\_\_\_\_

Have you had hives, rashes, swelling or trouble breathing after contact with rubber products, like balloons, gloves band-aids, elastic waistbands or condoms?  Yes  No

Have you ever experienced itching, swelling or other symptoms after dental, rectal, or pelvic exams?  Yes  No

Are you allergic to bananas, avocados, or water chestnuts?  Yes  No

Primary Care Physician: \_\_\_\_\_ Current Weight: \_\_\_\_\_

Have you ever had a Flexible Sigmoidoscopy/Colonoscopy, or Gastroscopy in the past? \_\_\_\_\_

Current complaints/symptoms \_\_\_\_\_

Hospitalizations/Surgeries (what & when) \_\_\_\_\_

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PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

**Do you have?**

- A Pacemaker
- A Defibrillator
- Dialysis Shunt
- Organ Transplant
- Artificial heart valve
- Heart Valve Problem
- Immune Problem
- Anxiety
- Depression
- High Cholesterol
- High Blood Pressure
- Heart Disease \_\_\_\_\_
- Diabetes
- Stroke
- Thyroid Problems
- Arthritis
- Asthma

- Lung Disease \_\_\_\_\_
- History of Cancer
- Liver Disease \_\_\_\_\_
- Hepatitis
- Kidney Disease
- Seizure Disorder
- Other \_\_\_\_\_

**Within the last 30 days have you had:**

- Abdominal Aneurysm Graft
- Joint Replacement
- Coronary Stent
- Defibrillator Placed
- Pacemaker Placed

If yes, bring pacemaker identification card with you.  
\*Please let your Doctor know if you have a pacemaker or defibrillator prior to your appointment day.

Do you have a history of problems with anesthesia/ sedation?  Yes  No

If you answered yes, what are the problems? \_\_\_\_\_

**Do you have a family history of any GI problems? List Age and Problem:**

Father: \_\_\_\_\_ Mother: \_\_\_\_\_

Brother / Sister: \_\_\_\_\_

**Smoking and Substance Alcohol History**

Have you ever regularly used tobacco products?  Yes  No If yes, how much? \_\_\_\_\_  
Do you use recreational drugs?  Yes  No If yes...  
What? \_\_\_\_\_ Date last used: \_\_\_\_\_  
Do you drink alcoholic beverages?  Yes  No If yes...  
What? \_\_\_\_\_ How much? \_\_\_\_\_ Date of last drink: \_\_\_\_\_

History reviewed by: \_\_\_\_\_ RN Date & Time \_\_\_\_\_

History reviewed by: \_\_\_\_\_ MD Date & Time \_\_\_\_\_

