

Name _____

Endoscopy/Medical Procedure Center
Preprocedure Medical History Form

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

In order to serve you most efficiently, please list your current medication, and include any over the counter medications, vitamins, or herbal supplements you are taking. This includes all aspirin, and anticoagulants that you have stopped for this procedure.

Medication & Dose

Date Last Taken

Name _____

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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) _____

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
- I-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 Substance1 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?(vol.) _____ date of last drink: _____

History reviewed by: _____ RN

History reviewed and medication reconciliation completed by: _____ MD

Name _____

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For registration purposes, please provide the following information about yourself:

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 other

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 other

Employer: _____

TYPE OF INSURANCE #2 _____ POLICY # _____

SUBSCRIBER NAME: _____ SUBSCRIBER BIRTHDATE: _____

SUBSCRIBER SOCIAL SECURITY #: _____

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

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 do 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? ____/____/____