

PRE-PROCEDURE HEALTH HISTORY ENDOSCOPY

Name: _____ Date of Birth: _____

Home Phone: _____ Sex: M F

Secondary Phone: _____

Primary Care Doctor & Phone Number: _____ Phone #: _____

A. Are you allergic to: Latex (rubber) Any foods Medications

(If you are allergic to latex, please call our nurse at 267-8200 at least one day prior to your procedure)

List medications/foods you are allergic to and the reactions to them: _____

B. List all medications you currently take:

Name of Medication	Dosage	# of times	Last Taken	Name of Medication	Dosage	# of times	Last Taken

C. Medical History: Do you now have or have you every had:

- | | | | | | |
|-----------------------------------|-----|----|--------------------------------------|-----|----|
| a) A heart attack | Yes | No | q) Kidney disease | Yes | No |
| b) Congestive Heart Failure | Yes | No | r) Bleeding problems? Describe _____ | Yes | No |
| c) Heart murmur | Yes | No | s) Tuberculosis (TB) | Yes | No |
| d) Rheumatic heart disease | Yes | No | t) Positive TB Test | Yes | No |
| e) Endocarditis (heart infection) | Yes | No | u) Exposure to someone with TB | Yes | No |
| f) Heart valve replacement | Yes | No | v) Colon Cancer | Yes | No |
| g) Chest pain | Yes | No | w) Family member with colon cancer | Yes | No |
| h) Chest pressure | Yes | No | x) Hepatitis | Yes | No |
| i) Irregular heart beat | Yes | No | y) Severe arthritis? Location _____ | Yes | No |
| j) Pacemaker/Defibrillator | Yes | No | z) Other Medical Problems _____ | | |
| k) Breathing problems | Yes | No | | | |
| l) Asthma | Yes | No | | | |
| m) Bronchitis | Yes | No | | | |
| n) High Blood Pressure | Yes | No | | | |
| o) Diabetes | Yes | No | | | |
| p) Seizure disorder | Yes | No | | | |

Your weight: lbs: _____ kgs: _____ Your height: _____

D) Do you smoke: Yes No If yes, how many? _____

E) Do you drink alcohol: Yes No If yes, how much? _____

F) List all previous surgeries, including dates: _____

H) Have you had any problems with anesthesia in the past? Yes No

If yes, please specify including when, where, and type of reaction: _____

I) Who will be driving you to and from Lindsay House Surgery Center? _____
(The person accompanying you must remain at the center throughout the procedure)

J) Do you have someone to stay with you? Yes No

K) Do you have any concerns or problems we should be aware of? Yes No

If yes, please explain: _____

L) Do you have an Advance Directive / Health Care Proxy / Living Will? Yes No

(Please bring this with you the day of your procedure)

L) Are you pregnant or suspect you might be pregnant? Yes No

If yes, please indicate the date of your last menstrual period: _____

Signature

Date

Do Not Write Below this Line

Patient History Form Reviewed by: _____, RN Date: _____

Comments: _____

Signature

Date