ROCHESTER GASTROENTEROLOGY ASSOCIATES LLP

Please **COMPLETE & BRING THIS THE DAY OF THE PROCEDURE**

PRE-PROCEDURE HEALTH HISTORY ENDOSCOPY

Name: _____ Date of Birth: _____

Home Phone: _____ Sex: ☐ M ☐ F

Secondary Phone: _____ Weight: _____

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

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

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			

20 Hagen Drive, Suite 330, Rochester, NY 14625
(585) 2674040 Fax—(585) 267-4044

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) Do you use recreational drugs: ☐ Yes ☐ No Comments _____

G) 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 Rochester Gastroenterology Associates Facility? _____
(The person accompanying you must remain at the center throughout the procedure)

J) Do you have someone to stay with you for 12—24 hours?

☐ 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

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

Comments: _____

_____

_____

_____

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