The GI Endoscopy Center sticker

Patient History

Primary Care Physician_____

Do you have any limitations to learning? None Learning disability Too Sick
Memory problems Language barrier

Any cultural/religious requests here at the Center? Yes No if so action_____

Who do you rely on for emotional support? Spouse Family Self Other_____

Have you had any of the following: (circle answers)

Diabetes	**Yes**	**No**	Lung/breathing problems	**Yes**	**No**	Kidney disease	**Yes**	**No**
GI disorder	**Yes**	**No**	Asthma	**Yes**	**No**	Thyroid disease	**Yes**	**No**
Heart disease	**Yes**	**No**	Emphysema/COPD	**Yes**	**No**	Cancer/_____	**Yes**	**No**
Irregular heart beat	**Yes**	**No**	Auto Immune Disorder	**Yes**	**No**	Hepatitis/jaundice	**Yes**	**No**
Heart murmur	**Yes**	**No**	Bleeding disorders	**Yes**	**No**	Musculoskeletal	**Yes**	**No**
Mitral valve prolapse	**Yes**	**No**	Neurological disorders	**Yes**	**No**	Prosthetic joints	**Yes**	**No**
Valve replacement	**Yes**	**No**	Seizure disorder	**Yes**	**No**	Tobacco/__Pks/day	**Yes**	**No**
Pacemaker/Defibrillator	**Yes**	**No**	Mental Health disorder	**Yes**	**No**	Drink alcohol	**Yes**	**No**
High Blood Pressure	**Yes**	**No**	Vision/Hearing loss	**Yes**	**No**	Recreational drugs	**Yes**	**No**
Stroke	**Yes**	**No**	Glaucoma	**Yes**	**No**	Anesthesia problems	**Yes**	**No**
Vascular grafts	**Yes**	**No**	Sleep Apnea	**Yes**	**No**	Post menopause	**Yes**	**No**
TB :Prod. cough	**Yes**	**No**	Weight loss 20lbs/2mon.	**Yes**	**No**	Night sweats	**Yes**	**No**

Females: Do you think you may be pregnant? YES NO Hysterectomy___ Tubal____

Explanation to above: _____

Past surgeries/hospitalization/procedures:_____

_____

Do you have a cardiologist? Yes No Name: _____ Date last visit: _____

DRUG ALLERGIES: _____

_____

ALL MEDICATIONS:including aspirin, anticoagulants, herbs, vitamins, supplements, etc.

Name/Dose/Frequency	Name/Dose/Frequency

PAIN: Do you have ongoing pain or discomfort? Yes No If yes , describe location:_____

Pain intensity on a scale of 1(least)-10 (most) Average_____

What makes your pain better?_____Worse?_____

Family Health History (Circle all that apply):

High Blood Pressure Stroke Diabetes Heart Disease
Stomach problems Colon Polyps Cancer

Patient Signature: _____ Significant other: _____

RN Confirming information: _____ 3/11cmh

It is the patient responsibility to give us accurate and current information in order for us to take care of you. **If you need assistance upon arrival to the center, please let us know prior to date or on preop phone call.**