

The GI Endoscopy Center  
**Patient History**

sticker

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: \_\_\_\_\_

8/10cmh

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.**