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## ENDOSCOPY PREPROCEDURE HIST PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU TO THE HOSPITAL ON THE DAY OF YOUR

EXAM. PLEASE DO NOT WEAR JEWELRY ON THE DAY OF YOUR EXAM.

NAME	_ Language spoken	Primary Care MD						
Why are you having this exam today?		Date of last exam						
Do <b>you</b> or a first degree relative such as mother disease or ulcerative colitis? If yes who:								
Do you need assistance walking? Y N	Need assistance of a cane	? Y N						
Do you use a wheel chair routinely? YN	Need assistance of a walker? YN							
Do you have hearing problems? Y N	Do you have any loose teeth? Y N							
Do you wear hearing aids? Y N Height Weight	Do you wear dentures? Y N							
	or opening your jaw wide? V	N						
Do you have any problems extending your neck or opening your jaw wide? Y N Have you had a problem with anesthesia in the past? Y N If yes, please explain								
Please list all past operations		-						
- I loude list all past operations								
Medical History: Do you have or ever had								
Breathing problems such as	Heart pro	oblems such as						
Asthma Y N	Had a he	art attack Y N						
Sleep apnea Y N	High bloc	od pressure Y N						
Routinely use C-Pap Y N	Heart valve problems Y N							
Emphysema Y N	Had a heart valve replacement Y N							
Shortness of breath Y N	Known heart murmur Y N							
Do you smoke? Y N Packs per day	Pace ma	ker Y N						
How many years smoking?	Implanted defibrillator Y N							
Do you have oxygen Y N Liters #	Cardiac stents Y N							
	Stroke/C	VA Y N						
Do you have diabetes? Y N	Do you h	ave history of seizures? Y N						
Kidney disease Y N	Date of la	ast seizure						
Do you have a history of hepatitis? Y N	Type Do you d	rink alcohol daily Y N						
Active Liver disease (hepatitis, cirrhosis) Y	N How m	nany drinks daily						
If you are pregnant please contact your prim	ary care physician as this m	nay affect your ability to have exam.						
What kind of prep did you take for this exam	today?							
1. Movie prep								
2. Other prep								
Comments								

**Continued on back** 



Patient Medication History	/			
Do you have any allergies to med Please list				
	oumadin or plavix?	Y N		
Do you take aspirin daily? Y		<u> </u>		
Please include all prescription, he nicotine, eye drops, and all over t	erbal supplements,	vitamins, and injectionstions, such as Tylenol,	s, medication patches, etc.	such as pain and
Medication	Dose	How Taken	How Often	Last Taken
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			Date	Time

\*\* PLEASE BRING THIS PAPER TO THE HOSPITAL THE DAY OF YOUR PROCEDURE \*\*

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Signature of nurse reviewing medical history with patient