PATIENT MEDICAL/SURGICAL HISTORY

Name: _____ **Name/Relationship Of Support Person:** _____
Allergies and Reactions: _____ **Is Support Person your driver ?** _____
Reason for procedure: _____ **Have you been here before? No Yes: Date** _____
Name of Colon Prep and Amount Taken: **Family/Referring physician**

PLEASE PROVIDE A LIST OF CURRENT MEDICATIONS ON THE BACK OF THIS FORM

PLEASE MARK ALL THAT APPLY:

HEART/CIRCULATION

- ☐ Abnormal rhythm
- ☐ Artificial Valve
- ☐ Chest Pain
- ☐ CHF
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Automatic Implantable Defibrillator
- ☐ Other:

LUNGS

- ☐ Asthma
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ COPD
- ☐ Sleep Apnea/C-Pap - Setting
- ☐ Other:

STOMACH/BOWELS

- ☐ Changes in bowel habits
- ☐ Abdominal Pain
- ☐ Difficulty Swallowing
- ☐ Colon Polyps
- ☐ Constipation
- ☐ Crohn's Disease / Colitis
- ☐ Diarrhea
- ☐ Diverticulosis
- ☐ Personal history of colon cancer
- ☐ Family history of colon cancer
- ☐ Reflux disease
- ☐ Hemorrhoids
- ☐ Ulcers
- ☐ Rectal Bleeding

DIABETIC Yes No

Height _____ Weight _____

☐Living Will ☐ Power of Attorney

KIDNEY, LIVER,THYROID

- ☐ Prostate cancer or Prostate disease
- ☐ Dialysis
- ☐ Kidney Stones
- ☐ Thyroid disease

NEURO/MUSCLE

- ☐ Amputation
- ☐ Arthritis
- ☐ Chronic Headache
- ☐ Migraines
- ☐ MS
- ☐ Neck/Back Pain
- ☐ Paralysis
- ☐ Prosthesis
- ☐ Seizures
- ☐ Stroke
- ☐ TMJ
- ☐ TIA
- ☐ Other:

MISC

- ☐ Anemia
- ☐ Auto immune
- ☐ Bleeding disorder
- ☐ Cancer- Location?_____
- ☐ Chemotherapy
- ☐ Lupus
- ☐ Steroid Use

PSYCHIATRIC

- ☐ Anxiety
- ☐ Depression
- ☐ Other:

GYN

- ☐ Pregnant
- ☐ Tubal Ligation
- ☐ Post-menopausal
- ☐ Hysterectomy

LIST SURGERIES:

_____
_____
_____
_____
_____
_____
_____
_____

PERSONAL PROBLEMS WITH ANESTHESIA

- ☐ Allergic Reaction
- ☐ Combative
- ☐ Persistent Nausea
- ☐ Persistent Vomiting
- ☐ Prolonged Sedation
- ☐ High Heart Rate
- ☐ Low/Unstable Blood Pressure
- ☐ Other:

DENTAL WORK

- ☐ Dentures
- ☐ Partial dental plates
- ☐ Removable dental work/Piercing

COMMUNICABLE DISEASE

- ☐ C. diff Date: _____
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Tuberculosis Date: _____
- ☐ MRSA Date: _____
- ☐ Other:

Recent exposure to illness or infection? **Y OR N**

SOCIAL HISTORY

		How much?	Years? / Prior?
Tobacco	Y or N		
Alcohol	Y or N		
Drugs	Y or N		

History and physical reviewed by:

Physician Signature: _____ **Date:** _____

Medication List

Please attach list or complete this section, including blood thinners, OTC medications and herbal supplements

NAME	DOSE	FREQUENCY	LAST TAKEN

Preferred Pharmacy (Name & Location):