PATIENT MEDICAL/SURGICAL HISTORY

Patient Name: _____ **Name/Relationship Of Support Person:** _____
ALLERGIES: _____ **Support Person Cell #:** _____
Name of Colon Prep Taken: _____ **% Drank:** _____

HEART/CIRCULATION

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

LUNGS

- □ Asthma
- □ Emphysema/COPD
- □ Shortness of Breath
- □ Tracheotomy
- □ Sleep Apnea/C-Pap - Setting ___
- □ Other:

STOMACH/BOWELS

- □ Changes in bowel habits/blood in stool
- □ Abdominal Pain
- □ Difficulty Swallowing
- □ Polyps
- □ Constipation
- □ Crohn's Disease
- □ Diarrhea
- □ Diverticulosis
- O Personal history of colon cancer
- O Family history of colon cancer
- □ Reflux disease
- □ Hemorrhoids
- □ Ulcers

DIABETIC Yes No Blood Sugar #___

KIDNEY, LIVER,THYROID

- □ Prostate cancer/disease
- □ Dialysis
- □ Kidney Stones
- □ Thyroid disease
- □ Other:

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
- □ Chemotherapy
- □ Lupus
- □ Steriod Use

PSYCHIATRIC

- □ Anxiety
- □ Depression
- □ Other:

GYN

- □ Pregnant
- □ Tubal Ligation
- □ Post-menopausal
- □ Hysterectomy

Height: _____

Weight_____

□Living Will □ Power of Attorney

LIST SURGERIES:

PERSONAL PROBLEMS WITH ANESTHESIA

- □ Allergic Reaction
- □ Combative
- □ Persistant Nausea
- □ Persisitant 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
- □ HIV/AIDS
- □ Hepatitis
- □ Tuberculosis
- □ MRSA
- □ Other:

Recent exposure to illness or infection?	Y OR N

- □ Known COVID Exposure
- □ COVID Symptoms □ Fever □ Cough □ Sore throat □ Headache □ Fatigue □ Loss of taste/smell

SOCIAL HISTORY

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

LIST MEDICATIONS ON BACK OF PAGE >>>

PATIENT MEDICAL/SURGICAL HISTORY

MEDICATIONS: ATTACH LIST IF YOU HAVE ONE- IF NOT PLEASE COMPLETE THIS SECTION (BLOOD THINNERS, OTC, HERBALS & VITAMINS)

Name	Dosage	Frequency	Last Taken

PREFERRED PHARMACY (NAME & LOCATION): _____