

Patient Profile

Please return this form to the endoscopy center 2 weeks prior to your procedure

Name (print): _____ **Date of Birth:** _____ **Procedure Date:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

Primary Care Physician: _____ **Reason for Procedure:** _____

Drug Allergies & Reaction: _____ **LATEX ALLERGY:** Y / N

PLEASE LIST ALL MEDICATIONS YOU TAKE, PRESCRIPTION AND NON-PRESCRIPTION

Medicine & Dose-Reason Taken	Medicine & Dose-Reason Taken	Medicine & Dose-Reason Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

BLOOD THINNERS: Do You Take: Aspirin, BC powder, Aleve, Motrin, Ibuprofen, Vitamin E
 Blood Thinners Such As: Coumadin Warfarin Plavix Levonox or Ticlid? Y / N

MEDICAL HISTORY

HEIGHT _____ **WEIGHT** _____

PLEASE CIRCLE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

CARDIAC: High Blood Pressure High Cholesterol Mitral Valve Prolapse Irregular Heart Rate Angina
 Heart Disease (TYPE) _____ Stent Pacemaker Heart Attack (MI) Congestive Heart Failure

PULMONARY: Asthma Emphysema COPD Sleep Apnea

GI: Acid Reflux Barrett's Esophagus Colitis / Crohn's Colon Polyps Colostomy Ulcers
 Diverticulosis / Diverticulitis Colon Cancer

GU: BPH Urinary Incontinence

KIDNEY/ENDOCRINE: Diabetes Kidney Failure / Dialysis Thyroid Problems

NEUROLOGIC/MUSCULAR: Stroke Parkinson's Migranes TIA'S Seizures: Date Of Last Seizure _____

PSYCHOLOGIC: Depression Anxiety Mental Illness (type) _____

AUTOIMMUNE: Rheumatoid / Osteo Arthritis Lupus HIV/AIDS

MISC: Anemia Bleeding Disorder Cancer (type): _____ Radiation / Chemotherapy Date: _____

Pregnant Y / N Breast Feeding Y / N

OTHER ILLNESSES NOT LISTED: _____

Do you have to take antibiotics before a medical or dental procedure? Y / N

FAMILY MEDICAL HISTORY

LIST FAMILY MEMBER THAT HAD THE FOLLOWING DISEASE (Immediate family only)

Cancer: Esophageal _____ Colon _____ Stomach _____ OTHER _____

Diabetes _____ High Blood Pressure _____ Heart / Lung Disease _____

ENDOSCOPY/SURGICAL HISTORY

DATE	SURGERY	DATE	SURGERY
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had any problems with anesthesia? Y / N _____

SOCIAL HISTORY

Do You Smoke? Y / N # Packs/day _____ Smokeless Y / N (amount) _____

Alcohol use: Never Occasionally Daily (# drinks/day) _____