

Raleigh Endoscopy Center Patient Health History Sheet:

Please fax or mail this form to the endoscopy center location to which you have been assigned (listed below)

ASAP or at least 3 days prior to exam date

Locations:

Main: 2417 Atrium Dr. (Fax) 919-791-2061 **North:** 8300 Health Park (Fax) 919-256-7981 **Cary:** 1505 SW Cary Parkway (Fax) 919-792-3061

Patient Name _____ Date of Birth _____ Procedure Date _____
Primary Care Physician _____ Height _____ Weight _____

******A RESPONSIBLE ADULT/DRIVER MUST REMAIN WITH YOU AT THE ENDOSCOPY CENTER AT ALL TIMES******

Please List Below any **Allergies/Sensitivities** to Medication, Materials, Food and Environmental factors and reaction:

Name and Reaction:

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

MEDICATIONS: LIST ALL (PRESCRIPTION, NON PRESCRIPTION, SUPPLEMENTS & VITAMINS)

<u>MEDICATION NAME</u>	<u>DOSE TAKEN</u>	<u>FREQUENCY</u>	<u>REASON TAKEN</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. Do you take a blood thinner?	Yes	No	Name: _____

Do you have any of the following? IF YES, contact your GI physician's office for further evaluation

Trouble Breathing or Anaphylaxis to Latex or Rubber Products?	Yes	No
Oxygen at Home to Help You Breathe?	Yes	No
A Letter Stating You Are Difficult to Intubate?	Yes	No
An Implanted AICD for Your Heart?	Yes	No
Currently Pregnant or Breast Feeding?	Yes	No
Currently on Dialysis?	Yes	No
Problems with Anesthesia (if so explain)	Yes	No
Take weight loss medications i.e., Phentermine	Yes	No

Have You Ever Been Diagnosed With the Following: (Please Circle if You Have Had or Currently Have?)

Congestive Heart Failure	Colon Cancer	Seizures (date of last) _____
Irregular Heart Beats	Cirrhosis	Stroke/TIA/CVA (date of last) _____
Chest Pain/Angina	Liver Disease	Infectious Diseases (type) _____
Heart Attack (Date) _____	Hepatitis(type) _____	Bleeding/Clotting Disorder (type) _____
Heart Stents (number) _____	Colostomy Bag	Cancer(type) _____
Shortness of Breath	Colitis/Crohns	Chemotherapy or Radiation: Dates _____
Sleep Apnea (CPAP setting) _____	Anemia	Shingles
COPD	C. Difficile	HIV/AIDS
Kidney Failure	Diabetes	High Blood Pressure
Do you Smoke/chew tobacco? _____	If Yes, Please Do NOT smoke/chew on the day of your procedure	
Drink Alcohol? _____ # of drinks/week _____	other/Misc.: (please list) _____	

Surgeries: Please List All Major Surgeries

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____