Raleigh Endoscopy Center Patient Health History Sheet:

Please complete this form and bring it with you on the day of your procedure.

Locations:

Main: **2417 Atrium Dr. (Phone) 919-791-2060** **North:** **8300 Health Park (Phone)919-256-7980** **Cary:** **1505 SW Cary Pkwy (Phone)919-792-3060**

Patient Name__________________________________ Date of Birth___________ Procedure Date___________

Primary Care Physician_______________________________ Height_________ Weight______________

******A RESPONISIBLE 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.________________________________ 4.____________________________ 7.__________________________

2.________________________________ 5.____________________________ 8.__________________________

3.________________________________ 6.____________________________ 9.__________________________

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

MEDICATION NAME DOSE TAKEN FREQUENCY REASON TAKEN

1.________________________________ _________ ________ ____

2. ________________________________ _________ ________ ____

3. ________________________________ _________ ________ ____

4. ________________________________ _________ ________ ____

5. ________________________________ _________ ________ ____

6. ________________________________ _________ ________ ____

7. ________________________________ _________ ________ ____

8. ________________________________ _________ ________ ____

9. ________________________________ _________ ________ ____

10. Do you take a blood thinner? Yes No Name:__________________________________

11. Do you take ANY OF THE FOLLOWING: Ozempic, Semaglutide, Mounjaro, Tirzepatide, Wegovy, Voictoza, Saxenda, Byetta, Trulicity?

12. Do you take Phentermine?

Do you have any of the following? IF YES, contact your GI physician's office for further evaluation Any one of these conditions could lead to a change in prep, or rescheduling or cancelation of your procedure.

Trouble Breathing or Anaphylaxis to Latex or Rubber Products? Yes No

Oxygen at Home to Help You Breath? 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 __________________________

Do you take any weight loss medications? Yes No

Do you take any diabetic medications? 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. Difficle	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.____