Name: _____ **DOB:** _____ **Date:**_____

Care Teams: Please list other physicians involved in your care.
PCP, GI, oncologist, OBGYN, cardiologist, etc

_____ _____ _____
_____ _____ _____

Allergies/Contraindications: Please list any allergies **AND** your reaction to the agent.

_____ _____ _____

Medication Review: Please list any current medications**,** including over the counter and supplements.
Name of medication/dose/frequency
Pharmacy: _____

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Medical History: Please check all that apply.
For items selected, please add pertinent information regarding that topic in the "comment" section.

- ☐ Anemia
- ☐ Anesthetic Complications
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ CHF
- ☐ Clotting Disorder
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ GERD
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hyperlipidemia
- ☐ HTN
- ☐ Inflammatory Bowel Disease
- ☐ Kidney Disease
- ☐ Myocardial Infarction (heart attack)
- ☐ Obesity
- ☐ Obstructive Sleep Apnea
- ☐ Osteoporosis
- ☐ Other Skin Cancer
- ☐ Pancreatitis
- ☐ Seizures
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Ulcerative Colitis

Surgical History: Please check all that apply.
For items selected, please add pertinent information regarding that topic in "comment" section.

- ☐ Appendectomy-*appendix*
- ☐ Breast Surgery
- ☐ CABG
- ☐ Cholecystectomy-*gallbladder*
- ☐ Colon Surgery
- ☐ C-section
- ☐ Diagnostic Laparoscopy
- ☐ Exploratory Laparotomy
- ☐ Fracture Surgery
- ☐ Gastric Bypass
- ☐ Groin Hernia Repair
- ☐ Hemorrhoidectomy
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Lap Band
- ☐ Small Intestine Surgery
- ☐ Spine Surgery
- ☐ Thyroid Surgery
- ☐ Tubal Ligation
- ☐ Valve Replacement
- ☐ Ventral Hernia Repair

Previous EGD/when?_____ Previous Colonoscopy/when?_____

Other Medical History/Surgical History/Comments:

_____

_____

_____

Family History: Please list any family history medical conditions.

Mother-*alive/deceased*: _____

Father-*alive/deceased*: _____

Siblings: _____

Children: _____

Aunts-*maternal/paternal:* _____

Uncles-*maternal/paternal*: _____

Grandparents-*maternal/paternal*: _____

Other: _____

Social History: Please complete the following.

Marital Status: _____ Children #: _____

Alcohol: YES/NO
What kind/how much?
_____

Tobacco Use: YES/NO
Packs/day?
_____

Drug Use: YES/NO
What type?
_____

Please put your height in the table below

NURSE USE ONLY:

Height:	
Weight:	
BP:	
Location/position:	
P:	
R:	
T:	