NASHVILLE ENDOSURGERY CENTER
(615) 284-1335

Please complete the following information so that we can provide you the best care.

Name______________________________Age_________Height______ Weight______

What is the reason you are having the procedure?____

Drug Allergies? Please List:____

Current Medications & Dosages:

Are you taking Aspirin or Blood Thinner?_______yes ________no

Do you have a heart murmur, a mechanical heart valve, or have you ever had Rheumatic fever? _______yes ____________no

Please list any previous surgeries and/or hospitalizations:

Chronic Medical problems: ____Asthma _____Heart Disease ____Hypertension ____Seizure Disorders___ Kidney Disease ____Infectious Disease
Other:____

Gastrointestinal Symptoms: __difficulty swallowing ___indigestion ___acid reflux ___abdominal pain ___nausea or vomiting ___ blood in stool ____previous ulcer disease ___constipation ___diarrhea ___black tarry stools

Do you have a family history of colon cancer? ___yes ___no If yes, who and what age?____

Do you have a family history of colon polyps? ____yes ___no If yes, who?______