Kaleida Health

DOWNTIME ☐ Entered into electronic record after downtime

date _____ time _____

initials _____

MR-
DOB-
ATT-
PCP-
FC-
Patient ID Area

PT-
AGE- SEX-

ADM DT-

# ENDOSCOPIC OUTPATIENT HISTORY 1 of 2

**DIRECTIONS: Please fill in this health history and bring it with you on the day of your procedure.**

Patient Name: _____

Referring or Primary Care Doctor: _____

Type of procedure: _____

Height: _____ Weight: _____

Allergies *(If you are allergic to LATEX, please notify your physician office PRIOR to the procedure)*: _____

**Please (✓) check all that apply:**

☐ Heart disease: unstable angina or chest pain

☐ Heart attack, when: _____

☐ Heart surgery, when: _____

☐ Hear murmur/ Heart valve replacement

☐ Pacemaker or Defibrillator (AICD)
*please bring manufacturers card*

☐ High blood pressure (hypertension)/ Stroke

☐ Lung disease: ☐ asthma ☐ emphysema ☐ bronchitis ☐ cancer

☐ Tuberculosis (TB) or positive TB testing

☐ History of blood clots

☐ Anemia/ Bleeding problems

☐ Multiple sclerosis/ Parkinson's

☐ Epilepsy/ Seizures

☐ Any chance of pregnancy?

☐ Date of last menstrual period: _____

☐ Cataracts/ Glaucoma

☐ Hearing problems

☐ Arthritis/ Gout/ Joint replacement

☐ Gallbladder disease/ Pancreatitis

☐ Liver disease/ Hepatitis

☐ Family history of cancer, who: _____

☐ Personal history of cancer, type: _____

☐ Diabetes

☐ Kidney disease

☐ History of ulcers

☐ Colitis/ Irritable bowel/ Proctitis

☐ Hiatal Hernia/ Reflux

☐ Difficulty swallowing

☐ Weight loss

☐ Hemorrhoids/ Rectal bleeding

☐ Diarrhea

☐ Constipation

☐ Abdominal pain/ Indigestion

☐ Nausea/ Vomiting

☐ Smoking, how much: _____ years: _____

☐ Use of alcohol (ETOH): _____

☐ Do you have any loose or capped teeth?

☐ Other: _____

Do you use blood thinners (anticoagulants), aspirin or aspirin products? ☐ No ☐ Yes, date last used: _____

(continued on back ➡)

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## ENDOSCOPIC OUTPATIENT HISTORY 2 of 2

### CURRENT MEDICATIONS

*Please list all current medications including name, dose, how often used (frequency), for what (indication), and last dose taken prior to procedure. Include medications used occasionally. If additional space is needed, please use a separate sheet of paper.*

| medication name | dose | how often (frequency) | for what (indication) | last dose taken |
|---|---|---|---|---|
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Please list all previous surgeries and any possible reaction to anesthesia (example, high fever): _____

**IF YOU RECEIVE SEDATION FOR YOUR PROCEDURE YOU MUST HAVE A RESPONSIBLE DRIVER TO ACCOMPANY YOU HOME FROM THE HOSPITAL.**

_____ _____

Date Patient Signature

_____ _____ _____

Date Time Nurse Reviewed (on day of procedure)

KH01195 Rev. 10/17/07

HISTORY & PHYSICAL