

# Patient Health History Form

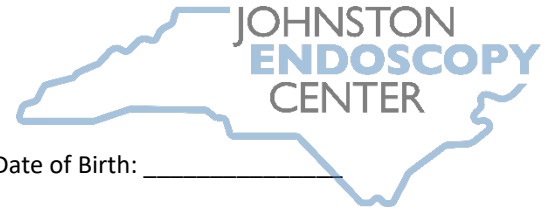
Please complete this form and bring it with you on your procedure day.

## Personal Information:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Procedure Date: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_



**Important: A responsible adult/driver must accompany you at the center for the duration of your visit.**

## Allergies/Sensitivities:

List any allergies or sensitivities to medication, materials, food, and environmental factors, including the name of the allergen and the reaction.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

## Medications:

Please list all medications (prescription, over-the-counter, supplements, and vitamins). Specifying their name, dose, frequency, and purpose.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

## Health Screening Checklist:

Are you currently taking any of the medications listed below?

- [ ] Yes [ ] No Blood thinner: (Name: \_\_\_\_\_)
- [ ] Yes [ ] No Medications (Ozempic, Semaglutide, Mounjaro, Tirzepatide, Wegovy, Voictoza, Saxenda, Byetta, Trulicity, Phentermine)

## Health Conditions Checklist:

Do you have any of the following:

**If YES to any below, contact your GI physician's office for further evaluation.**

- [ ] Yes [ ] No Trouble Breathing/Anaphylaxis to Latex
- [ ] Yes [ ] No Oxygen at Home
- [ ] Yes [ ] No Difficult to Intubate
- [ ] Yes [ ] No Implanted AICD
- [ ] Yes [ ] No Pregnant
- [ ] Yes [ ] No On Dialysis
- [ ] Yes [ ] No Weight Loss Medications
- [ ] Yes [ ] No Diabetic Medications
- [ ] Yes [ ] No Problems with Anesthesia (Explain: \_\_\_\_\_)

## Lifestyle:

Tobacco Use: [ ] No [ ] Yes (Do not use on day of procedure)

Alcohol Consumption: [ ] No [ ] Yes (# of drinks/week: \_\_\_\_\_)

Other/Misc.: \_\_\_\_\_

## Medical History:

Have You Ever Been Diagnosed With:

- [ ] Yes [ ] No - Congestive Heart Failure
- [ ] Yes [ ] No - Colon Cancer
- [ ] Yes [ ] No - Seizures
- [ ] Yes [ ] No - Irregular Heart Beats
- [ ] Yes [ ] No - Cirrhosis
- [ ] Yes [ ] No - Stroke/TIA/CVA
- [ ] Yes [ ] No - Chest Pain/Angina
- [ ] Yes [ ] No - Liver Disease
- [ ] Yes [ ] No - Infectious Diseases
- [ ] Yes [ ] No - Heart Attack
- [ ] Yes [ ] No - Hepatitis
- [ ] Yes [ ] No - Bleeding/Clotting Disorders
- [ ] Yes [ ] No - Heart Stents
- [ ] Yes [ ] No - Colostomy Bag
- [ ] Yes [ ] No - Cancer
- [ ] Yes [ ] No - Shortness of Breath
- [ ] Yes [ ] No - Colitis/Crohn's
- [ ] Yes [ ] No - Chemotherapy or Radiation
- [ ] Yes [ ] No - Sleep Apnea
- [ ] Yes [ ] No - Anemia
- [ ] Yes [ ] No - Shingles
- [ ] Yes [ ] No - COPD
- [ ] Yes [ ] No - C. Difficile
- [ ] Yes [ ] No - HIV/AIDS
- [ ] Yes [ ] No - Kidney Failure
- [ ] Yes [ ] No - Diabetes
- [ ] Yes [ ] No - High Blood Pressure

## Surgeries:

List all major surgeries.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

**Ensure all information is accurate and complete for the best possible care.**