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.

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