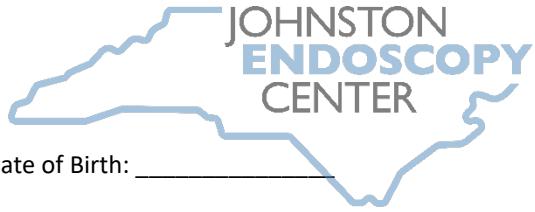


Patient Health History Form

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.