METROPOLITAN
GASTROENTEROLOGY
CONSULTANTS

ASGE Quality
ENDOSCOPY UNIT RECOGNITION PROGRAM

PATIENT HISTORY FORM

NAME _____ DATE _____

AGE _____ HEIGHT _____ WEIGHT _____ REFERRING DOCTOR _____

I. MAIN COMPLAINT - THE MAIN REASON YOU ARE SEEING THE DOCTOR TODAY: *Check Only One*

____ Abnormal Liver Tests	____ Constipation	____ GERD-Heartburn-Indigestion	____ Painful Swallowing
____ Bloating	____ Diarrhea	____ Hepatitis	____ Positive Stool Cards
____ Blood in Stool	____ Difficulty Swallowing	____ Lower Abdominal Pain	____ Upper Abdominal Pain
____ Change In Bowel Habits	____ Fever	____ Nausea	____ Weight Loss
			____ Vomiting

Other _____

II. OTHER SYMPTOMS YOU ARE HAVING: PLEASE CIRCLE YES OR NO

Bloating	Yes - No	Diarrhea	Yes - No	Nausea	Yes - No
Blood in Stool	Yes - No	Difficulty Swallowing	Yes - No	Painful Swallowing	Yes - No
Change in Bowel Habits	Yes - No	Fever	Yes - No	Upper Abdominal Pain	Yes - No
Constipation	Yes - No	Lower Abdominal Pain	Yes - No	Weight Loss	Yes - No

Other _____

Would you like to discuss the new nonsurgical weight loss procedures with the Doctor? Yes - No

III. REVIEW OF SYSTEMS - IF YOU ARE CURRENTLY EXPERIENCING: PLEASE CIRCLE YES OR NO

CONSTITUTIONAL

Fatigue	Yes - No
Fever	Yes - No
Loss of Appetite	Yes - No
Night Sweats	Yes - No
Rigors	Yes - No
Weight Loss	Yes - No
Weight Gain	Yes - No

Other _____

EYES

Eye Pain	Yes - No
Sudden Change in Vision	Yes - No

Other _____

EARS-NOSE-MOUTH-THROAT

Bad Breath	Yes - No
Ears Ringing	Yes - No
Hearing Loss	Yes - No
Hoarseness	Yes - No
Nose Bleeds	Yes - No
Post Nasal Drip	Yes - No
Sore Throat	Yes - No

Other _____

RESPIRATORY

Cough	Yes - No
Shortness of Breath	Yes - No
Wheezing	Yes - No

Other _____

CARDIOVASCULAR

Chest Pain	Yes - No
Edema	Yes - No
Palpitation	Yes - No

Other _____

GENITOURINARY

Blood in Urine	Yes - No
Difficulty Starting Urine Stream	Yes - No
Frequent Urination	Yes - No
Painful Urination	Yes - No

Other _____

GYNECOLOGY

Abnormal Vaginal Bleeding	Yes - No
Vaginal Discharge	Yes - No
Is there any chance you could be pregnant?	Yes - No

Other _____

MUSCULOSKELETAL

Back Pain	Yes - No
Joint Pain	Yes - No
Morning Stiffness	Yes - No
Raynaud's	Yes - No

Other _____

NEUROLOGICAL

Weakness on either side	Yes - No
Abnormal skin sensations or sensitivity	Yes - No
Headaches	Yes - No

Other _____

INTEGUMENTARY

Breast Discharge	Yes - No
Breast Lump	Yes - No
Breast Pain	Yes - No
Itching	Yes - No
Rash	Yes - No

Other _____

PSYCHIATRIC

Anxiety Disorder	Yes - No
Depression	Yes - No
Panic Attack	Yes - No
Sleep Disorder	Yes - No

Other _____

ENDOCRINE

Change in Hair Pattern	Yes - No
Dry Skin	Yes - No
Heat Cold Intolerance	Yes - No

Other _____

HEMATOLOGIC / LYMPHATIC

Anemia	Yes - No
Bleeding / Bruising Tendency	Yes - No
Enlarged Lymph Nodes	Yes - No

Other _____

ALLERGIC / IMMUNOLOGIC

Chronic Nasal Congestion	Yes - No
Chronic Runny Nose	Yes - No
Frequent Sneezing	Yes - No
Watery Itchy Eyes	Yes - No

Other _____

IV. GENERAL MEDICAL HISTORY

Arthritis	Yes - No	Diabetes	Yes - No		
Collagen Vascular Disease	Yes - No	High Blood Pressure	Yes - No	Heart Murmur	Yes - No
Dialysis	Yes - No	Congestive Heart Failure	Yes - No	Mitral Valve Prolapse	Yes - No
Kidney Disease	Yes - No	Heart Disease	Yes - No	Lung Disease	Yes - No
Heart Attack	Yes - No	Heart Valve Replacement/Disease	Yes - No	Sleep Apnea	Yes - No
If yes, give date _____		Heart Stents	Yes - No	C-PAP Machine	Yes - No
		If yes, give date _____		Heavy Snoring	Yes - No

GI PAST MEDICAL HISTORY

HAVE YOU EVER HAD A COLONOSCOPY? YES - NO

Colon Polyps	Yes - No	Ulcer Disease	Yes - No	Liver Disease	Yes - No
Colon Cancer	Yes - No	Irritable Bowel Syndrome	Yes - No	Pancreatitis	Yes - No
GI Bleeding	Yes - No	Inflammatory Bowel Disease -		Reflux (GERD)	Yes - No
Other _____		Ulcerative Colitis - Crohn's	Yes - No		

PAST SURGICAL HISTORY

Please list all operations you have had:

_____ _____

_____ _____

_____ _____

_____ _____

Do you have sleep apnea? _____ **Do you use a C-PAP machine?** _____ ***Please bring your machine with you for your procedure*

Have you ever experienced an adverse reaction (low blood pressure/heart rate, difficulty breathing, etc.) to intravenous sedations or anesthesia? Yes or No

If yes, for what operation/procedure _____ **Date of procedure** _____

Blood Transfusion? Yes or No When? _____

Have you ever donated blood/plasma/platelets in the past? Yes or No If yes, year of last donation _____

Have you ever been refused as a blood donor in the past? Yes or No If yes, why? _____

Radiation? Yes or No When? _____ **Are you allergic to Lidocaine? Yes or No**

Drug *Allergies*? Yes or No Are you allergic to eggs? Yes or No Are you allergic to soy? Yes or No

Are you allergic to latex? Yes or No

Please List:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Are you currently taking prescription or over the counter medication? Yes or No

List all medicines you are taking (prescription and non-prescription) Please list all pain medicine, sleeping pills or nerve pills you are taking even if you only take them occasionally.

Medicine	Dosage	Times/day	Medicine	Dosage	Times/day	Medicine	Dosage	Times/day

Do you use alcohol Yes or No Amount _____

Do you use tobacco Yes or No Packs per day _____

Do you use drugs Yes or No Type _____

Do you have a family history of the following:		**Who**	**Type (if known)**
High Blood Pressure	**Yes or No**		
Early Heart Disease	**Yes or No**		
Diabetes	**Yes or No**		
Cancer	**Yes or No**		
Colon Polyps	**Yes or No**		
Colon Cancer	**Yes or No**		
Inflammatory Bowel Disease	**Yes or No**		
Liver Disease	**Yes or No**		