G.I. MEDICINE ASSOCIATES P.C.

PRE-ENDOSCOPY HISTORY FORM

First Name:	**Last Name:**
DOB: **Age:**	**Height:** **Weight:**
Address:	**City:** **Zip:**
Home Phone:	**Cell Phone:**
Email:	**Pharmacy Name/Phone Number:**
Referring Physician:	**Referring Physician Number:**

Primary Insurance:	**Subscriber Name/DOB**
ID #:	**Group #:**
Secondary Insurance:	**Subscriber Name/DOB**
ID #:	**Group #:**

WHAT PROCEDURE ARE YOU REQUESTING TO HAVE SCHEDULED? ☐ **EGD** ☐ **COLONOSCOPY** ☐ **EUS**

Do you have difficulty swallowing? □ Yes □ No

Do you have Chronic Cough? □ Yes □ No

Do you have Achalasia? □ Yes □ No

Do you have Barrett's Esophagus? □ Yes □ No

When was your last Colonoscopy? _____ Where was it done? _____

When was your last EGD? _____ Where was it done? _____

Personal History of Colon polyps? □ Yes □ No Family members with colon polyps? Who? _____

Personal History of Colon Cancer? □ Yes □ No Family members with Colon Cancer? Who? _____

Personal History of Colitis / Crohn's Disease? □ Yes □ No Age of Diagnosis: _____

Do you take a blood thinner? □ Yes □ No Circle which one: Coumadin (Warfarin), Plavix (Clopidogrel), Effient (Prasugrel), Pradaxa (Dabigatran), Xarelto (Rivaroxaben), Eliquis (Apixaban), Brilinta (Tircagrelor), Aggrenox (dipyridamole), Pletal (Cilostazol), Other _____

Do you have a Defibrillator? □ Yes □ No Manufacturer: _____

Do you have a Pacemaker? □ Yes □ No

Do you have a mechanical valve? □ Yes □ No

Cardiologist Name/Phone number:

_____

Have you had Endocarditis? □ Yes □ No Have you had total hip or knee replacement? □ Yes □ No When? _____

Do you have a bleeding disorder? **Von Willebrand's** □ Yes □ No **Factor V** □ Yes □ No

MTHFR Gene □ Yes □ No **ITP Gene** □ Yes □ No Other _____

PERTINTENT MEDICAL HISTORY:

Cardiac	**Kidney**	**Liver/Pancreas**	**Gastrointestinal**
□ Hypertension □ Atrial Fibrillation □ Coronary Artery Disease □ Myocardial Infarction □ Congestive Heart Failure	□ Renal Insufficiency □ Dialysis	□ Cirrhosis □ Jaundice □ Pancreatitis □ Hepatitis _____	□ GERD / Reflux □ Bloating □ Food getting stuck □ Abdominal pain □ Blood in stool
Respiratory/Pulmonary	**Neurological**	**Other**	□ Diarrhea □ Constipation □ Change in bowel habits
□ Asthma □ Emphysema / COPD □ Sleep Apnea □ Use C-Pap □ Use Oxygen at home □ Use Bi-Pap	□ Stroke □ Seizure □ Dementia/Alzheimer's □ Psychiatric disorders □ Parkinson's □ Multiple Sclerosis	□ Diabetes / □ Insulin □ Alcoholism Quit:_____ □ Drug Abuse Quit:_____ □ Epidermolysis Bullosa □ Malignant Hyperthermia □ Myasthenia Gravis □ HIV / AIDS	

What surgeries did you have in the past? □ CABG / Heart bypass □ Colon resection

□ Gallbladder removed □ Gastric bypass □ Hysterectomy □ Prostatectomy

□ Stents put in the heart □ Valve replacement □ Other _____

Do you have any personal history of cancer? What type? _____

Do you use tobacco/nicotine products? □ Yes □ No How often do you consume alcohol? _____

Do you have difficulty walking or need assistance accessing the exam table? _____

Have you ever had problems with anesthesia or difficulty being sedated? □ I never had anesthesia before □ No

□ Yes (please explain) _____

Allergies / Reaction: _____

_____

Medications: _____

_____

_____

Please indicate who we should speak with regarding your medical history and scheduling your procedure:

□ Self □ Spouse □ Child □ Caregiver □ Parent □ Other _____

Name: _____ Phone: _____

Date Completed: _____

Patient name: _____ **DOB:** _____