

Middlesex Digestive Health and Endoscopy Center
Pre-Procedure Medical Form

Name: _____

Date of Birth: _____

Height _____ Weight _____

Place an (X) in the appropriate box

Do you have a history of?

Cardiac Problems:

Yes No

- High Blood Pressure
- Valve Replacement
- Heart Murmur/Palpatations
- Angina/Heart Attack
- Pacemaker
- AICD (defibrillator)
- Bypass or angioplasty
- Swelling of Extremities

Other: _____

Respiratory Problems:

Yes No

- Asthma
- Sleep Apnea

Other: _____

Kidney/Prostate Problems

Yes No

- Kidney Failure

Men Only:

- Prostate Enlargement
- Prostate Cancer

Other: _____

Liver/Gallbladder Problems:

Yes No

- Hepatitis A B C
- Cirrhosis/Liver Disease
- Gallbladder Disease/Surgery
- Recreational Drug Use
- Alcohol Use

Amount: _____

Other: _____

Neurological Problems:

Yes No

- Stroke
- Seizure
- Headache
- Dizziness
- TIA

Blood Disorders:

Yes No

- Anemia
- Clotting Disorders
- Bruising

Other: _____

Endocrine Problems:

Yes No

- Diabetes° Insulin° Oral° Diet
- Thyroid problems

Orthopedic Problems:

Yes No

- Arthritis _____ Site
- Joint Replacement _____
- Metal pins, rods, plates: _____

Mental Status:

Yes No

- Depression
- Confusion
- Anxiety/Panic Disorders

Women Only:

Yes No

- Hysterectomy
- Mastectomy/Lumpectomy R L
- Are you pregnant? LMP _____

GI Problems:

Yes No

- Family History of Colon Cancer
Relationship: _____
- Personal History of Colon Cancer
- Family History of Colon Polyps
Relationship: _____
- Personal History of Colon Polyps
- Diverticulosis/Diverticulitis
- Colitis/Crohns
- Irritable Bowel Syndrome
- Bleeding
- Constipation/Diarrhea
- Stomach Ulcers
- Barretts Disease
- Esophageal Strictures/Choking
- Weight Loss/Nausea/Vomiting

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Name: _____

Primary Care Physician:

Name: _____

Address: _____

Pharmacy Info:

Name: _____

Phone: _____

Please list any other Medical/Surgical History:

Yes No Do you have a history of requiring antibiotics prior to dental work or medical procedures?

Yes No Do you have a Health Care Proxy? If yes, bring a copy to procedure if available.

Yes No May we leave a message on your home or work answering machine regarding your care?

Latex Allergy? Yes No

Food Allergy? Please list: _____

Medication Allergy? Please list: _____

Please List ALL Current Medications/Vitamins (Prescriptions and Over the Counter)

<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>	<u>Last Dose</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. _____	_____	_____	_____
11. _____	_____	_____	_____
12. _____	_____	_____	_____

Patient Signature: _____ Date: _____

This information has been reviewed and updated with the patient just prior to the procedure.

Admitting Nurse Signature: _____ Date: _____