HUNTSVILLE ENDOSCOPY CENTER
History & Physical

Patient Name	Age	DOB	Date

Check all conditions that apply to patient only.

AIRWAY/COMPLICATIONS WITH SEDATION/ANESTHESIA

- ❑ Difficult Intubation (Breathing Tube Insertion)
- ❑ TMJ/Limited Mouth Opening
- ❑ Extreme Nausea/Vomiting
- ❑ Awareness During Procedure
- ❑ Missing/Loose teeth
- ❑ Dentures/Partials
- ❑ Difficulty Waking Up
- ❑ Other _____

CARDIAC/CARDIOLOGIST: _____

- ❑ HTN (High Blood Pressure)
- ❑ Chest Pain
- ❑ High Cholesterol
- ❑ Heart Disease/Abnormalities *If yes, explain below:
  * _____
- ❑ Irregular Heart Rhythm *If yes, explain below:
  * _____
- ❑ Heart Attack/MI If yes, date: _____
- ❑ Pacemaker/Defibrillator
- ❑ Heart Stent Placement If yes, date: _____
- ❑ Aneurysm
- ❑ Other _____

PULMONARY

- ❑ Recent Cold/Respiratory Infection/Fever
- ❑ Chronic Cough
- ❑ Home Oxygen (O^2)
- ❑ Asthma/Wheezing If yes, use inhaler? _____
- ❑ SOB/Shortness of Breath
- ❑ COPD/Emphysema
- ❑ Sleep Apnea/Snoring If yes, use CPAP? _____
- ❑ Steroid Use Within Last 6 Months
- ❑ CHF (Congestive Heart Failure)
- ❑ Tuberculosis If yes, date: _____
- ❑ Other _____

GASTROINTESTINAL

- ❑ GERD (Reflux)
- ❑ Ulcerative Colitis
- ❑ Crohn's Disease
- ❑ IBS (Spastic Colon)
- ❑ History of Colon Polyps
- ❑ Cirrhosis
- ❑ Celiac Disease
- ❑ Barrett's Esophagus
- ❑ Nausea/Vomiting
- ❑ Heartburn
- ❑ Abdominal Pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Appetite Loss
- ❑ Weight Loss
- ❑ Blood in Stool
- ❑ Vomiting Blood
- ❑ Rectal Pain
- ❑ Liver Disease/Hepatitis ❍ A ❍ B ❍ C
- ❑ Dysphagia/Difficulty Swallowing
- ❑ Other _____

NEURO

- ❑ Seizures *If yes, explain below:
  * _____
- ❑ Paralysis
- ❑ Neuropathy
- ❑ Stroke/TIA
- ❑ Migraines
- ❑ Parkinson's/Tremors
- ❑ Dementia/Alzheimer's
- ❑ Mental Disability/Intellectual Disability
- ❑ Other _____

RENAL

- ❑ Kidney Disease
- ❑ Dialysis
- ❑ Edema/Fluid Retention
- ❑ Prostate Enlargement
- ❑ Other _____

ENDOCRINE

- ❑ Diabetes ❍ IDDM/Insulin ❍ NIDDM/Non-Insulin
- ❑ Thyroid Disease
- ❑ Pancreatic Disease
- ❑ Other _____

MUSCULOSKELETAL

- ❑ Arthritis ❍ Osteoarthritis ❍ Rheumatoid Arthritis
- ❑ Multiple Sclerosis
- ❑ Fibromyalgia
- ❑ Chronic Back/Neck Pain
- ❑ Gout
- ❑ Other _____

OTHER

- ❑ CANCER of ❍ Colon ❍ Other
- ❑ Bleeding Disorder *If yes, explain below:
  * _____
- ❑ Anemia
- ❑ HIV/AIDS
- ❑ Other Infectious Disease _____
- ❑ SKIN: ❑ Open Wounds ❑ Lesions ❑ Burns ❑ Bruising
  If yes, location: _____
- ❑ Other _____

PSYCHIATRIC

- ❑ Anxiety/Depression
- ❑ ADD/ADHD
- ❑ Mental Disorder *If yes, explain below:
  * _____

SOCIAL HISTORY

- ❑ Cigarettes _____packs per _____day_____ years
- ❑ Other Tobacco Use _____
- ❑ Alcohol If yes, how much/often? _____
- ❑ Drugs ❑ Marijuana ❑ Cocaine ❑ Meth
- ❑ Other _____

Patient Name

PROCEDURE: ❍ Colonoscopy ❍ Esophagogastroduodenoscopy ❍ Flexible Sigmoidoscopy ❍ Other

Reason for Today's Procedure/Symptom: _____

_____

_____

ALLERGIES/REACTIONS

_____

_____

_____

_____

PREVIOUS SURGERIES

_____

_____

_____

_____

_____

_____

_____

MEDICATIONS

List all PRESCRIBED and OVER-THE-COUNTER Medications

❑ **Check here if list was provided TODAY by patient.**

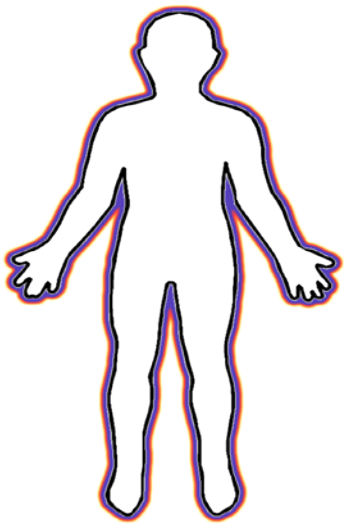
If no list provided, please complete below.

MEDICATIONS	DOSAGE	LAST DOSE

Indicate Location of Any METAL

❑ **NONE**

Right **Left**



Advanced Directive (for Healthcare) ❍ **YES** ❍ **NO**

If yes, copy on chart ❍ **YES** ❍ **NO**

Patient Label