GLEN ENDOSCOPY CENTER

PATIENT HISTORY

Name: _____ Referring Physician: _____

Age: _____ Date of Birth: _____

A) REASON FOR VISIT

_____

_____

How does this affect your lifestyle? _____

_____

Increased Appetite? Yes _____ No _____

Decreased Appetite? Yes _____ No _____

Recent Weight Change? Yes _____ No _____

If "yes" how much over what length of time?

_____

Prior problems with anesthesia? Yes___ No ___

If "yes", please describe_____

_____

B) PATIENT PROFILE (CIRCLE ONE)

Married Divorced Single Separated Widowed

Have you had a sigmoidoscopy or barium enema?

____ No ____ Yes; Date of test _____

Last medical examination _____

Occupation: _____

Years retired: _____Since _____

Hobbies/Interests _____

Smoking: Pipe_____Cigarettes _____

Chewing Tobacco_____

Coffee: More than two cups per day _____

Alcohol: _____ _____glasses per day

_____

Beer/Wine:_____ _____glasses per day

_____

C) MEDICATION ALLERGIES _____

_____

_____

Signature

_____

Nurse Signature Indicating Review

_____

Physician Signature Indicating Review

D) HOSPITALIZATION AND/OR SURGERIES

_____

_____

_____

E) Do you have pain now or have you had pain in the last several weeks? Yes___ No___ If yes, how would you rate the level of pain on a scale of 1-10 with 10 being the worst? _____ Describe the pain. Where is it located? What aggravates it? What alleviates it? How long does it last? _____

_____

_____

_____

F) MEDICINES

Please list all medicines taken daily or routinely, with or without prescriptions, including birth control bills, vitamins, aspirin arthritis or pain pills, herbal and/or dietary supplements

_____

_____

_____

_____

_____

_____

_____

G) MEDICAL HISTORY (Please Circle)

High Blood Pressure, Heart Disease, Diabetes,

Kidney Problems, Liver Disease, Arthritis, Breathing Difficulty

Vision Problems, Stroke, Seizures, Hearing Difficulty

Other _____

_____

_____

Date

_____

Date

_____

Date