GLEN ENDOSCOPY CENTER

PATIENT HISTORY

Name: _____ Referring Physician: _____

Age: _____ Date of Birth: _____

A) REASON FOR VISIT

_____

_____

_____

_____

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)

Date of last Colonoscopy: _____

Date of last EGD: _____

Occupation: _____

Years retired: _____ Since _____

Smoking: Pipe _____ Cigarettes _____

Alcohol: _____ _____glasses per day

Recreational Drug Use: _____

_____

C) MEDICATION ALLERGIES: _____

_____

_____

_____

_____

D) FOOD ALLERGIES: _____

_____

_____

_____

_____

E) ENVIRONMENTAL ALLERGIES: _____

_____

_____

_____

_____

F) HOSPITALIZATION AND/OR SURGERIES

_____

_____

_____

_____

_____

_____

_____

_____

_____

G) MEDICINES

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

H) MEDICAL HISTORY (Please Circle)

High Blood Pressure, Heart Disease, Diabetes
Kidney Problems, Liver Disease, Arthritis,
Breathing Difficulty, Vision Problems, Stroke, Seizures,
Hearing Difficulty, HIV, Hepatitis, Sleep Apnea, Cancer,
Auto Immune Disease

Other _____

_____

_____

_____

_____