Space Coast Endoscopy Center
PREVENTIVE HEALTH. PERSONAL CARE.
1974 Rockledge Blvd • Suite 102 • Rockledge FL 32955
T: 321 504 4440 • F: 321 504 4470

PATIENT HISTORY

PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU FOR THE PROCEDURE.

❑ Y ❑ N Allergies/type of reaction:_____ **Procedure:** ❑ EGD ❑ Colon
_____ Other: _____

❑ Y ❑ N Latex Allergy
❑ Y ❑ N Egg, Soy or Sulfite Food Allergy
❑ Y ❑ N Any anesthesia complications in past/in family
❑ Y ❑ N Heart problems (Heart Attack, Coronary Artery Disease, Valve Replacement, Mitral Valve Prolapse, Angina, Pacemaker, Atrial Fib, Internal Defibrillator)
❑ Y ❑ N High Blood Pressure, Low Blood Pressure
❑ Y ❑ N Breathing Problems (Asthma, Bronchitis, COPD, Emphysema, TB, Sleep Apnea)
❑ Y ❑ N Diabetes - controlled by (diet, pills, insulin)
❑ Y ❑ N Kidney problems (Dialysis)
❑ Y ❑ N Liver Disease (Hepatitis)
❑ Y ❑ N Personal history of Cancer - Type: _____
❑ Y ❑ N Stroke, Weakness in limb, Seizure disorder
❑ Y ❑ N Bone or Muscle Disorder, back or neck problems, arthritis
❑ Y ❑ N Surgery (Abdominal, Hernia, Hysterectomy, Joint Replacements)
Other(s): _____
❑ Y ❑ N Blood Problems (Anemia, bleeding disorder)
❑ Y ❑ N Daily Aspirin/Blood Thinners. Last Dose: _____
❑ Y ❑ N Pregnant ___ N/A ___ LMP _____
❑ Y ❑ N Smoker/Ex-Smoker _____ pack(s) per day Ht _____ Wt _____
❑ Y ❑ N Alcohol intake (occasional, _____ per day)
❑ Y ❑ N Advanced Directives/Living Will: Location: ___ Home ___ Other
Information requested? ___ Yes ___ No _____ given to patient

PLEASE COMPLETE MEDICATION LIST ON BACK OF SHEET

Remember: Be sure to take your heart, BP, seizure or asthma medicines in the morning before coming for your procedure.

Name and Phone of Ride Home: _____ Pharmacy: _____ Location: _____

Here in lobby or phone _____ Nurse Signature:_____

Reviewed by Anesthesia Provider Signature: _____

OVER →

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PATIENT MEDICATION LIST

Name: _____

The doctor doing your procedure will give you instructions regarding which medications you may need to discontinue before your procedure. Please call the office if you have any questions.

Please list any medications you take on a regular basis, including prescription, herbal supplements, vitamins, and over the counter medications.

❑ No Routine Medications

Medication Name	**Dosage** (mg, units)	**Frequency** (daily, 2 times/day as needed, etc.)	**Date Last Taken**	May resume after procedure **(to be completed by MD after test)**
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

Pre op Signatures: Date _____

_____
Nurse

_____
Anesthesia Provider

Post Procedure: Date _____

_____
Discharge Nurse

_____
Physician

❑ Reviewed and copy given to patient