



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.**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Allergies/type of reaction: _____<br>_____  | <b>Procedure:</b> <input type="checkbox"/> EGD <input type="checkbox"/> Colon<br>Other: _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Latex Allergy   |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Egg, Soy or Sulfite Food Allergy  |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Any anesthesia complications in past/in family  |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Heart problems (Heart Attack, Coronary Artery Disease, Valve Replacement, Mitral Valve Prolapse, Angina, Pacemaker, Atrial Fib, Internal Defibrillator) |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | High Blood Pressure, Low Blood Pressure   |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Breathing Problems (Asthma, Bronchitis, COPD, Emphysema, TB, Sleep Apnea)   |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Diabetes - controlled by (diet, pills, insulin)   |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Kidney problems (Dialysis)  |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Liver Disease (Hepatitis)   |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Personal history of Cancer - Type: _____  |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Stroke, Weakness in limb, Seizure disorder  |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Bone or Muscle Disorder, back or neck problems, arthritis   |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Surgery (Abdominal, Hernia, Hysterectomy, Joint Replacements)<br>Other(s): _____  |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Blood Problems (Anemia, bleeding disorder)  |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Daily Aspirin/Blood Thinners. Last Dose: _____  |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Pregnant ___ N/A ___ LMP _____  |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Smoker/Ex-Smoker _____ pack(s) per day  | Ht _____ Wt _____   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Alcohol intake (occasional, _____ per day)  |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Advanced Directives/Living Will: Location: ___ Home ___ Other<br>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: \_\_\_\_\_





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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 <b>(to be completed by MD after test)</b>
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Pre op Signatures: Date \_\_\_\_\_

Post Procedure: Date \_\_\_\_\_

\_\_\_\_\_  
 Nurse

\_\_\_\_\_  
 Discharge Nurse

\_\_\_\_\_  
 Anesthesia Provider

\_\_\_\_\_  
 Physician

Reviewed and copy given to patient