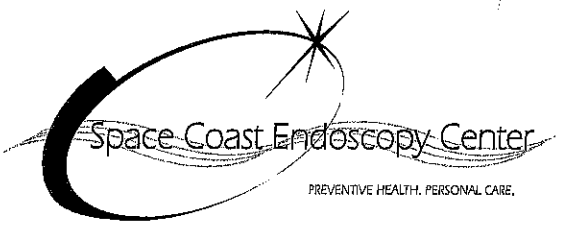
PATIENT INFORMATION



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PATIENTS NAME: _____ HOME TELEPHONE: _____

CELLULAR NUMBER: _____ E-MAIL: _____

PERMANENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PRIMARY LANGUAGE: _____

DATE OF BIRTH: _____ AGE: _____ MALE: _____ FEMALE: _____

PATIENTS SOCIAL SECURITY # : _____ MARITAL STATUS: _____

RACE: ❑ ASIAN ❑ BLACK ❑ NATIVE HAWAIIAN/PAC ISLAND ❑ HISPANIC ❑ AMERICAN INDIAN/ALASKAN NATIVE

❑ UNKNOWN ❑ WHITE, NON-HISPANIC ❑ OTHER _____

REFERRED BY OR PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT (NOT LIVING WITH PATIENT)

NAME: _____

TELEPHONE: _____ RELATIONSHIP: _____

❑ INSURANCE CARD COPIED

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PATIENT HISTORY

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

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

❑ Y ❑ N Latex 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, Cardiac Surgeries)
❑ 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 Autoimmune disorder
❑ 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 Recreational drug use: Type _____ Last used _____
❑ 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:_____

OFFICE USE ONLY:
❑ Y ❑ N
May be present when physician talks to patient.

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

Pre op Signatures: Date _____

_____
Nurse

_____
Anesthesia Provider

Post Procedure: Date _____

_____
Discharge Nurse

_____
Physician

❑ Reviewed and copy given to patient