



1974 Rockledge Blvd • Suite 102 • Rockledge FL 32955  
T: 321 504 4440 • F: 321 504 4470

**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

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

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

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Nurse

## Discharge Nurse

## Anesthesia Provider

## Physician

Reviewed and copy given to patient