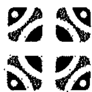

Kaleida Health

DOWNTIME
☐ Entered into electronic record after downtime
date ______ time ______
initials ______

ENDOSCOPIC OUTPATIENT HISTORY

MR-
DOB-
ATT-
PCP-
FC-
PT-
AGE-
SEX-
ADM DT-
Patient ID Area

If you receive sedation for your procedure you <u>must</u> have a responsible driver to accompany you home from the hospital.

<u>Directions: Please fill in this health history and bring it with you on the day of your procedure.</u>

Patient Name ______________________

Referring or Primary Care Doctor ______________________

Type of procedure ______________________

Height ______________ Weight ______________

Allergies *(If you are allergic to LATEX, please notify your physician office PRIOR to the procedure)* ______________________

____

____

____

____

Date of last colonoscopy ______________ Date of last EGD ______________

Please (✓) check all that apply

☐ Heart disease; unstable angina or chest pain
☐ Heart attack, when ______________
☐ Heart surgery, when ______________
☐ Hear murmur/ heart valve replacement
☐ Pacemaker or defibrillator (AICD)
please bring manufacturers card
☐ High blood pressure (hypertension)/ stroke
☐ Lung disease ☐ asthma ☐ emphysema ☐ bronchitis ☐ cancer
☐ Tuberculosis (TB) or positive TB testing
☐ History of blood clots
☐ Anemia/ bleeding problems
☐ Multiple sclerosis/ Parkinson's
☐ Epilepsy/ seizures
☐ Any chance of pregnancy?
☐ Date of last menstrual period ______________
☐ Cataracts/ glaucoma
☐ Hearing problems
☐ Arthritis/ gout/ joint replacement
☐ Gallbladder disease/ pancreatitis

☐ Liver disease/ hepatitis
☐ Family history of cancer, who ______________
☐ Personal history of cancer, type ______________
☐ Diabetes
☐ Kidney disease
☐ History of ulcers
☐ Colitis/ irritable bowel/ proctitis
☐ Hiatal hernia/ reflux
☐ Difficulty swallowing
☐ Weight loss
☐ Hemorrhoids/ rectal bleeding
☐ Diarrhea
☐ Constipation
☐ Abdominal pain/ indigestion
☐ Nausea/ vomiting
☐ Smoking, how much ______________ years ______________
☐ Use of alcohol ______________
☐ Do you have any loose or capped teeth?
☐ Other ______________

(continued on back ➠)

Kaleida Health

DOWNTIME
☐ Entered into electronic record after downtime

______ date ______ time

______ initials

ENDOSCOPIC OUTPATIENT HISTORY

MR-
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Patient ID Area

Current Medications

Please list all current medications including name, dose, how often used (frequency), for what (indication), and last dose taken prior to procedure. Include medications used occasionally. If additional space is needed, please use a separate sheet of paper.

Do you use blood thinners (anticoagulants), aspirin or aspirin products? ☐ No ☐ Yes, date last used ______

Medication Name	Dose	How Often (frequency)	For What (indication)	Last Dose Taken

Please list all previous surgeries and any possible reaction to anesthesia (example, high fever) ______

______

______

______

______ Date

______ Patient Signature

______ Date ______ Time

______ Nurse Reviewed (on day of procedure)

KH01195 Rev. 03/15/16

HISTORY & PHYSICAL