Endoscopy Center of Colorado Springs

Patient Information Sheet

Name______________________________ Sex: □ F □ M DOB___________ Age_______ Date _________

Primary Care Physician: ________________________ Primary Care Physician's phone #:_____________

Reason I'm having this procedure: ____

PAST MEDICAL AND SURGICAL HISTORY (Circle Yes or No) Do you now or have you ever had:

Medical Condition	**Yes**	**No**	**Comments**	**Medical Condition**	**Yes**	**No**	**Comments**
Heart Problems	Yes	No		Stomach Problems/Ulcers	Yes	No	
High Blood Pressure	Yes	No		Celiac Disease	Yes	No	
Heart Murmur	Yes	No		Crohn's Disease	Yes	No	
High Cholesterol	Yes	No		Colitis	Yes	No	
Chest Pain/Angina	Yes	No		Jaundice	Yes	No	
Abnormal Heart Rhythm	Yes	No		Hepatitis/Liver Problems	Yes	No	
Pacemaker/Internal Defibrillator	Yes	No		Anemia	Yes	No	
Breathing Problems	Yes	No		Bleeding Disorder	Yes	No	
Asthma	Yes	No		Kidney Problems	Yes	No	
Pneumonia	Yes	No		Thyroid Problems	Yes	No	
Emphysema	Yes	No		Arthritis/Joint Problems	Yes	No	
Pulmonary Embolism	Yes	No		Stroke	Yes	No	
Tuberculosis	Yes	No		Epilepsy/Seizures	Yes	No	
Sleep Apnea	Yes	No		Headaches/Fainting/Dizziness	Yes	No	
Diabetes	Yes	No		Glaucoma	Yes	No	
Swallowing Difficulties	Yes	No		Cancer, Type:	Yes	No	
Gastric Reflux/Heartburn	Yes	No		Blood or Infectious Disease	Yes	No	
Hiatal Hernia	Yes	No		Anxiety/Depression	Yes	No	
Other Medical Conditions (please list):							

Past Surgery	**Yes**	**No**	**Comments**	**Past Surgery**	**Yes**	**No**	**Comments**
Colon	Yes	No		C-section	Yes	No	
Stomach	Yes	No		Breast	Yes	No	
Heart	Yes	No		Other surgeries:			
Joint Replacement	Yes	No		Other surgeries:			
Gallbladder	Yes	No		Other surgeries:			
Hysterectomy	Yes	No		Other surgeries:			
Appendectomy	Yes	No		Anesthesia Problems	Yes	No	
Prostate	Yes	No		Previous EGD	Yes	No	
Bladder	Yes	No		Previous Colonoscopy	Yes	No	

Social History (Past or Present)	**Yes**	**No**	**Quit Date**	**Amount**
Tobacco	Yes	No	Quit	
Alcohol	Yes	No	Quit	
Caffeine	Yes	No	Quit	
Recreational Drug Use	Yes	No	Quit	
Do you exercise?	Yes	No	How much?	

Name:_______________________________________

Family History: Please indicate any **RELATIVES** with the following diseases.

Colon Cancer	Yes	No		Celiac Disease	Yes	No	
Colon/Rectal Polyps	Yes	No		Gallstones	Yes	No	
Crohn's Disease	Yes	No		Hemochromatosis	Yes	No	
Colitis	Yes	No		Heart disease	Yes	No	
Diabetes	Yes	No		High Blood Pressure	Yes	No	
Anesthesia Problems	Yes	No		Liver Disease	Yes	No	

Symptom Review Check (☒) symptoms you currently have or have had in the past

☐ Weight Loss	☐ Cough	☐ Frequent urination	☐ Memory loss
☐ Fever/Chills	☐ Shortness of breath	☐ Incontinence of urine	☐ Depression
☐ Poor vision/double vision	☐ Heart burn	☐ Difficulty urinating	☐ Anxiety
☐ Dry mouth	☐ Nausea / vomiting	☐ Blood in urine	☐ Hair loss
☐ Frequent nosebleeds	☐ Swallowing difficulties	☐ Arthritis/Joint pain	☐ Hot/Cold sensitivity
☐ Hearing loss	☐ Pain with swallowing	☐ Muscle aches	☐ Excessive thirst
☐ Nasal congestion	☐ Abdominal pain	☐ New or chronic rash	☐ Easy bruising
☐ Hoarseness	☐ Diarrhea	☐ Nail changes	☐ Excessive bleeding
☐ Chest pain	☐ Constipation	☐ Headaches	☐ Swollen lymph nodes
☐ Irregular heart beat	☐ Blood in stool	☐ Seizures	☐ Swelling of ankles/legs

Other:

Other:

Other Physicians Who Are Actively Treating You:

Physician:	Condition:
Physician:	Condition:
Physician:	Condition:
Physician:	Condition:

My_________________(family member), _________________(name) **has been treated by this same Gastroenterologist.**

DO NOT WRITE BELOW THIS LINE. PHYSICIAN AREA ONLY

History Reviewed by:

If this form was filled out more than 30 days ago physician will review and update:

Updated____________ Physician Signature:___________________________

Updated____________ Physician Signature:____________________________

Updated____________ Physician Signature:____________________________

Endoscopy Center of Colorado Springs

Medication and Allergy List

Name____ DOB______________ Procedure Date _________

It is important for your physician and anesthesia provider to have a complete list of your medications and allergies. Please help us by taking the time to provide us a list of your allergies and all your medications (Both over-the-counter and prescription), supplements, and pumps/patches as accurately and completely as possible. Thank you.

Active Allergy List

☐ No known allergies

Allergy	Reaction	Severity	Comments

Latex Allergy? YES NO Iodine Allergy? YES NO Egg Allergy? YES NO

Active Medication List

☐ No present medications/supplements

Medication	Dose	Route	Frequency	Reason	Taken Today?	Date Last Taken
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	