



PATIENT MEDICAL HISTORY FORM

(PLEASE PRINT)

NAME: _____ TODAY'S DATE: ____/____/____

DATE OF BIRTH: ____/____/____ HEIGHT: _____ WEIGHT: _____

NAME OF PCP: _____ *How did you hear about PEC?* _____

MEDICATIONS – Please list all your current prescription and non-prescription medications, vitamins, and supplements:
 NONE

Name	Dosage	Last Dose		Name	Dosage	Last Dose

MEDICAL HISTORY – Please check all that apply:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Chronic anxiety | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Positive stool guaiac |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Colon cancer, personal history | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Reaction to anesthesia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Colon cancer, family history | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Respiratory _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Colon cancer, Relation: _____ | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Colon polyps | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Barium enema | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Kidney disease/failure | <input type="checkbox"/> Stroke/paralysis |
| <input type="checkbox"/> Black/tarry stool | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Change in bowl habits | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Lupus | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Cardiac disorder _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Chest pain/angina _____ | | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Trouble swallowing |
| | | <input type="checkbox"/> Neurological _____ | |

Tobacco use, frequency: _____ Alcohol use, frequency: _____

Pregnant/LMP ____/____/____ Nursing Port-O-Cath™ Pacemaker/Internal Defibrillator

ALLERGIES

NONE Penicillin Sulfa Aspirin Iodine Latex Other(s): _____

SURGICAL HISTORY

NONE List procedures and dates: _____

IMPORTANT NOTICE

Please be advised that for your safety and protection, driving any motorized vehicle after moderate sedation is prohibited for at least 24 hours. A responsible adult over the age of 18 must also accompany you home after your procedure. WE STRONGLY ENCOURAGE THAT THIS PERSON REMAIN WAITING FOR YOU AT THE FACILITY. If this is not possible, this person must be readily available to pick you up when called and sign you out before you are discharged. Delays caused by late/no transportation could result in additional patient charges. Thus, you agree to be fully responsible for all charges incurred as a result of your failure to arrange proper transportation home.

Name of person to call to pick you up: _____ Phone #: (____) _____

Patient's Signature: _____

Reviewed by RN: _____ Date: ____/____/____ Time: _____