Dayton Gastro Endoscopy

(937) 320-5050
(800) 341-5055
www.daytongastro.com

Medical History

Today's Date _____

Name *(First, Middle, Last)* _____ Date of Birth _____

Medical History

Medical History – Please check any of the medical conditions for which you have seen a doctor.

- ❑ None
- ❑ Anemia
- ❑ Anxiety Disorder
- Arthritis
  - ❑ Osteoarthritis
  - ❑ Rheumatoid
- ❑ Asthma
- Cancer
  - ❑ Breast
  - ❑ Colon
  - ❑ Esophageal
  - ❑ Kidney
  - ❑ Liver
  - ❑ Lung
  - ❑ Ovarian
  - ❑ Prostate
  - ❑ Stomach
  - ❑ Uterine
- ❑ Celiac Sprue
- ❑ Colon Polyps
- ❑ Congestive Heart Failure
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Crohn's Disease
- Dementia/Alzheimer's
  - ❑ Dementia
  - ❑ Alzheimer's
- ❑ Depression
- ❑ Diabetes
- Diverticular Disease
  - ❑ Diverticulitis
  - ❑ Diverticulosis
- ❑ Emphysema
- Esophageal Disease
  - ❑ Barret's Esophagus
  - ❑ Varices
- ❑ Fibromyalgia
- ❑ Gallstones
- ❑ Glaucoma
- ❑ Headache, migraine
- Heart Arrhythmias
  - ❑ Atrial Fibrillation
  - ❑ Tachycardia
  - ❑ Bradycardia
  - ❑ SVT
- ❑ Heart Attack
- ❑ Heart Valve Disease
- ❑ Hemorrhoids
- Hepatitis/Liver Disease
  - ❑ Cirrhosis
  - ❑ Hepatitis A
  - ❑ Hepatitis B
  - ❑ Hepatitis C
  - ❑ Hepatitis Other _____
  - ❑ Jaundice
- ❑ Hiatal Hernia
- ❑ High Blood Pressure
- ❑ High Cholesterol (lipids)
- ❑ HIV
- ❑ Irritable Bowel Syndrome
- ❑ Kidney/Renal Disease
- ❑ Kidney Stones
- ❑ Pancreatitis
- ❑ Parkinson's Disease
- ❑ Reflux (GERD)
- ❑ Seizure disorder
- ❑ Sjogren's Disease
- ❑ Sleep Apnea/CPAP
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Ulcerative Colitis
- ❑ Other *(please list):*

_____
_____
_____

Surgical History

Surgical History – Please check any of the surgeries that you have had.

- ❑ None
- ❑ Appendix Removal
- ❑ Back Surgery
- ❑ Bilateral Tubal Ligation
- ❑ Blood Transfusions
- ❑ Carpal Tunnel Release
- Colon Surgery
  - ❑ Colectomy
  - ❑ Partial Colectomy
  - ❑ Colostomy
  - ❑ Ileostomy
- ❑ C-Section
- Feeding tube
  - ❑ G tube
  - ❑ J tube
- ❑ Gallbladder Surgery
- Gastric Bypass/ Weight Loss Surgery
  - ❑ Duodenal Switch
  - ❑ Gastric Sleeve
  - ❑ Roux en Y
- ❑ Heart Stents _____ *(mm/yyyy)*
- ❑ Heart Surgery/Bypass
- ❑ Heart Valve Replacement, Aortic
- ❑ Heart Valve Replacement, Mitral
- ❑ Hernia Repair
- ❑ Hiatal Hernia Surgery
- ❑ Hysterectomy
- ❑ ICD (Internal Cardiac Defibrillator)
- Joint Replacement/Joint Surgery
  - ❑ Hip replacement
  - ❑ Knee replacement
  - ❑ Shoulder replacement
  - ❑ Joint Surgery _____
- ❑ Laparoscopy (abdominal)
- ❑ Liver Biopsy
- ❑ Lung Surgery
- ❑ Mastectomy (Breast) Surgery
- ❑ Pacemaker
- ❑ Prostate
- ❑ Small bowel resection
- Throat/Mouth Surgery
  - ❑ Tonsillectomy
  - ❑ Adenoidectomy
  - ❑ Wisdom Teeth
  - ❑ Other _____
- ❑ Thyroidectomy
- ❑ Transplant
- ❑ Other *(please list):*

_____
_____
_____

Social History

What is your occupation? _____

Are you:
❑ Single ❑ Married ❑ Widowed
❑ Partner ❑ Divorced/Separated

Do you use tobacco?
❑ No
❑ Quit *(year)* _____ age started ____ age stopped ____
❑ Yes type _____
# of years ____ packs per day ____

Do you consume alcoholic drinks? ❑ No ❑ Yes ❑ Quit *(year)* _____
Type _____
Frequency/Amount _____

Do you drink/consume caffeine? ❑ No ❑ Yes
Type _____
Amount per day _____

Do you currently use recreational drugs? ❑ No ❑ Yes
Type _____
Frequency _____

Don't forget to complete the other side of this form >>

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Medical History (continued)

Today's Date _____

Name *(First, Middle, Last)* _____ Date of Birth _____

Family History

		Father	Mother	Children	Brother	Sister	Other Relatives
Colon	Colon or Rectal Cancer	❑ at age _____	❑ at age _____	❑ at age _____	❑ at age _____	❑ at age _____	❑ _____
Colon	Colon Polyps	❑ at age _____	❑ at age _____	❑ at age _____	❑ at age _____	❑ at age _____	❑ _____
Other	Crohn's Disease	❑	❑	❑	❑	❑	❑ _____
Other	Esophageal Cancer	❑	❑	❑	❑	❑	❑ _____
Other	Kidney Cancer	❑	❑	❑	❑	❑	❑ _____
Other	Liver Cancer	❑	❑	❑	❑	❑	❑ _____
Other	Liver Disease	❑	❑	❑	❑	❑	❑ _____
Other	Ovarian Cancer	N/A	❑	❑	N/A	❑	❑ _____
Other	Pancreatitis	❑	❑	❑	❑	❑	❑ _____
Other	Stomach Cancer	❑	❑	❑	❑	❑	❑ _____
Other	Ulcerative Colitis	❑	❑	❑	❑	❑	❑ _____
Other	Uterine Cancer	N/A	❑	❑	N/A	❑	❑ _____
Other	Other Cancer *(please specify):*	❑ _____ at age _____	❑ _____ at age _____	❑ _____ at age _____	❑ _____ at age _____	❑ _____ at age _____	❑ _____

Don't forget to complete the other side of this form >>

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Review of Systems

Today's Date _____

Name *(First, Middle, Last)* _____ Date of Birth _____

Review of Systems

Have you had any of these symptoms recently?

Constitutional
- Weight loss ❑ Yes ❑ No

Respiratory
- Chronic cough ❑ Yes ❑ No
- Spitting up blood ❑ Yes ❑ No
- Wheezing ❑ Yes ❑ No
- Snoring ❑ Yes ❑ No

Cardiovascular
- Chest pain ❑ Yes ❑ No
- Shortness of breath ❑ Yes ❑ No
- Swelling of ankles ❑ Yes ❑ No

Gastrointestinal
- Difficulty swallowing ❑ Yes ❑ No
- Heartburn ❑ Yes ❑ No
- Nausea ❑ Yes ❑ No
- Vomiting ❑ Yes ❑ No
- Bloating ❑ Yes ❑ No
- Belching ❑ Yes ❑ No
- Regurgitation ❑ Yes ❑ No
- Constipation ❑ Yes ❑ No
- Diarrhea ❑ Yes ❑ No
- Abdominal pain ❑ Yes ❑ No
- Rectal bleeding ❑ Yes ❑ No

Female Genitourinary
- Possibility of pregnancy ❑ Yes ❑ No
- Currently breastfeeding ❑ Yes ❑ No

Neurological
- Seizures ❑ Yes ❑ No
- Numbness ❑ Yes ❑ No
- Weakness ❑ Yes ❑ No

Psychiatric
- Depression ❑ Yes ❑ No
- Nervousness/anxiety ❑ Yes ❑ No

Integumentary
- Rash ❑ Yes ❑ No

Hematologic/Lymphatic
- Easy bleeding ❑ Yes ❑ No
- Easy bruising ❑ Yes ❑ No
- Anemia ❑ Yes ❑ No
- Sickle Cell anemia ❑ Yes ❑ No

Comments on any of the above symptoms: _____

_____

Directives

Advance Healthcare Directives

Do you have a living will? ❑ Yes ❑ No

Do you have a durable Power of Attorney for healthcare? ❑ Yes ❑ No

Do you have any other advance directives? ❑ Yes ❑ No

Anesthesia

Anesthesia Reaction

Have you ever had a reaction to anesthesia? ❑ No ❑ Yes – describe: _____

Is there any family history of reaction to anesthesia? ❑ No ❑ Yes – describe: _____

General

General

Do you have any of the following?

❑ Contact lenses ❑ Hearing aids ❑ Loose, chipped or damaged teeth

❑ Eyeglasses ❑ Dentures or removable dental appliance ❑ Mouth or nose piercing

Pre-Procedure

Pre-Procedure

When did you last eat food? Date: _____ Time: _____

When was the last time you drank fluids, including any prep you have taken? Date: _____ Time: _____

Do you take a prescription blood thinner?

❑ No ❑ Yes – name of blood thinner: _____ Last dose: _____

Are you diabetic?

❑ No ❑ Yes – last blood sugar result: _____ Date: _____ Time: _____

Colon

Colon Procedures only:

If you took a bowel cleanse preparation, how much did you complete? ❑ 25% ❑ 50% ❑ 75% ❑ 100%

Was your last bowel movement clear liquid with no solid stool? ❑ Yes ❑ No

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Medications and Allergies - Please Print

Patient Info

Today's Date_____

Name *(First, Middle, Last)*_____ Date of Birth_____

Allergies/Reactions

Please list any allergies or reactions to medications, foods, latex or dyes.
Please list what type of reaction you experienced (example: difficulty breathing, hives, etc.)

_____

_____

_____

Medications/Dosages

Please list all your medications and doses. Include vitamins, herbal supplements and over-the-counter medications (example: ibuprofen, Advil, Aleve, aspirin, Excedrin, Motrin, etc.).

Medication	Dosage	How Often Taken

Pharmacy

Please provide the following information for your preferred pharmacy.

Pharmacy Name _____ Address _____

Pharmacy Phone Number _____