

Austin Endoscopy Center

Patient Health History

Family Physician _____

Reason for today's procedure _____

Specific Stomach or Bowel Problems: _____

Please list your current medications, dosages, and how often you take them.

_____	mg.	_____	times per day	_____
_____	mg.	_____	times per day	_____
_____	mg.	_____	times per day	_____
_____	mg.	_____	times per day	_____
_____	mg.	_____	times per day	_____

ALLERGIES TO MEDICATIONS: _____

PLEASE CHECK ALL CONDITIONS THAT **YOU** HAVE PRESENTLY, HAVE HAD IN THE PAST, OR ARE TAKING MEDICATION FOR NOW

- | | |
|--|--|
| <input type="checkbox"/> HEART VALVE DISEASE | <input type="checkbox"/> STROKE/TIA (fainting spells) |
| <input type="checkbox"/> CORONARY ARTERY DISEASE | <input type="checkbox"/> STENOSIS(narrowing of the blood vessels) |
| <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> NEUROPATHY(numbsness/tingling) |
| <input type="checkbox"/> ANGINA(chest pain) | <input type="checkbox"/> GERD (indigestion/heartburn) |
| <input type="checkbox"/> ARRHYTHMIA(irregular heart beats) | <input type="checkbox"/> IRRITABLE BOWEL(constipation/diarrhea) |
| <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> POLYPS/ULCERS |
| <input type="checkbox"/> PERIPHERAL VASCULAR DISEASE | <input type="checkbox"/> HEPATITIS what type: _____ |
| <input type="checkbox"/> CONGESTIVE HEART FAILURE | <input type="checkbox"/> HERNIA where: _____ |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> ARTHRITIS where: _____ |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> INJURIES |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> DIABETES do you take insulin or pills |
| <input type="checkbox"/> SLEEP APNEA | <input type="checkbox"/> GLAUCOMA |
| <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> THYROID REPLACEMENT |
| <input type="checkbox"/> COPD | <input type="checkbox"/> PREGNANCY when was your last period _____ |
| <input type="checkbox"/> SEIZURES | <input type="checkbox"/> CANCER where and when: _____ |
| <input type="checkbox"/> FAINTING SPELLS | <input type="checkbox"/> PROSTHETICS |
| <input type="checkbox"/> ANXIETY/DEPRESSION | |

Have you ever been sedated or received anesthesia? _____

Were there any problems? (Ex. NAUSEA, VOMITING, DIFFICULTY WAKING UP) _____

How often do you use aspirin or Ibuprofen (Motrin, Aleve, etc.) _____

When was your last dose? _____

Is there anything else about YOUR health history that we should know? _____

Patient Signature _____ Date: _____