Patient Label Here

LAKESIDE ENDOSCOPY CENTER, LLC
PATIENT HISTORY FORM

REASON FOR PROCEDURE (CHECK ALL THAT APPLY):

❒ Screening Colonoscopy
❒ Family history of colon cancer
❒ Personal history of colon polyps/cancer
❒ Personal history of Crohn's Disease
❒ Personal history of Ulcerative Colitis
❒ Blood in stool/rectal bleeding
❒ Reflux
❒ Difficulty swallowing
❒ Nausea/Vomiting
❒ Bloating/Gas
❒ Increased appetite
❒ Decreased appetite
❒ Unintentional weight change:
Gained _____ pounds/Lost _____ pounds
Over how much time? _____
❒ Other : _____
❒ Pain: _____
_____
❒ Location: _____

Please circle one:

1 2 3 4 5 6 7 8 9 10
Very Mild ⟶ Severe

Onset/Duration: _____
Type of Pain: _____
Triggers: _____
Relief: _____

Tobacco Use: ❒ Never ❒ Former ❒ Current
If current: ❒ Daily ❒ Occasionally Amount: _____
Alcohol Use: ❒ Never ❒ Former ❒ Current
If current: ❒ Daily ❒ Occasionally Amount: _____
Caffeine Use: ❒ Yes ❒ No ❒ Rarely

PATIENT MEDICAL HISTORY (CHECK ALL THAT APPLY):

❒ Stroke
❒ High Blood Pressure
❒ Low Blood Pressure
❒ Cholesterol
❒ Diabetes: ❒ Type I ❒ Type II
Please specify
❒ Lung Disease _____
❒ Kidney Disease_____
❒ Heart Disease _____
❒ Liver Disease _____
❒ Thyroid Disease _____
❒ Cancer _____
❒ Seizures Date of last seizure :_____
❒ Arthritis _____
❒ Other Diseases _____
_____
❒ Other Infections _____
_____

❒ Hearing Difficulty: ❒ Right Ear ❒ Left Ear ❒ Both
❒ Vision Difficulty _____
❒ Other: _____
_____

Date of last medical examination: _____

Prior Anesthesia Problems: ❒ None or please specify:
_____
_____
_____

WOMEN ONLY: Are you currently pregnant? ❒ Yes ❒ No

Allergies & Reactions

_____
_____
_____
_____

Prior Surgeries– please list

_____
_____
_____
_____

Prior Hospitalizations – please list

_____
_____
_____
_____

_____ _____
Patient Signature Date

_____ _____
Reviewing Nurse's Signature Date