

Patient Label Here

MIDWEST ENDOSCOPY SERVICES, 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

Allergies & Reactions

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

Prior Surgeries- please list

Blank lines for listing prior surgeries.

Prior Hospitalizations - please list

Blank lines for listing prior hospitalizations.

Patient Signature

Date

Reviewing Nurse's Signature

Date