ENDOSCOPIC SURGICAL CENTRE OF MARYLAND, LLC

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Silver Spring, MD 20901
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TTY Users Call Maryland Relay #711

HISTORY SCREENING FORM

Please complete this form accurately to assist us in providing the best care possible. Place a question mark in any space you are not sure about or do not understand. We will clarify any questions. **BRING THIS COMPLETED FORM WITH YOU TO THE ENDOSCOPIC SURGICAL CENTRE OF MARYLAND ON THE DAY OF YOUR PROCEDURE**

PATIENT:_____ PHYSICIAN: _____

PROCEDURE: _____ DATE OF PROCEDURE:_____

Have you had this or a similar procedure before? ☐Yes ☐No If yes, when: _____

List all surgical procedures you have had and any implanted devices (artificial joints, pacemaker, defibrillator, etc.)

_____
_____
_____
_____

Did you ever have a problem with anesthesia or sedation? ☐Yes ☐ No Comment: _____

Indicate any special Religious, Cultural, or Language needs: _____

List the medications to which you are allergic: _____

Are you advised to take antibiotics before dental work? ☐ Yes ☐ No Why: _____

Do you take blood thinners, aspirin, or aspirin like drugs routinely? ☐ Yes ☐ No Height: _____ Weight: _____

Daily Medications

Medication	Dose	Times Taken	Medication	Dose	Times Taken

Last Menstrual Period_____

Could you be pregnant? ☐ Yes ☐ No Have you had any blood transfusions? ☐ Yes ☐ No Any Reactions to blood transfusions? ☐ Yes ☐ No

IF YOU HAD OR STILL HAVE ANY OF THE FOLLOWING PLEASE CHECK.

BRONCHITIS, CHRONIC COUGH ☐	ANEMIA ☐	DIABETES ☐ LOW BLOOD SUGAR ☐
ASTHMA ☐	HIGH BLOOD PRESSURE ☐	THYROID TROUBLE ☐
PNEUMONIA ☐	LOW BLOOD PRESSURE ☐	KIDNEY TROUBLE ☐
TUBERCULOSIS ☐	JAUNDICE, HEPATITIS ☐	PHYSICAL DISABILITIES ☐
EMPHYSEMA ☐	LIVER PROBLEMS ☐	HISTORY OF MENTAL ILLNESS ☐
SHORTNESS OF BREATH ☐	COLON POLYPS ☐	H PYLORI ☐
DO YOU SMOKE? ☐ YES ☐ NO # PACKS/DAY	COLON CANCER ☐	GASTRITIS OR ULCERS ☐
RHEUMATIC FEVER OR MITRAL VALVE PROLAPSE ☐	BACK PAIN OR INJURY ☐	CANCER- GASTRIC ☐ ESOPHAGEAL ☐
CHEST PAIN OR ANGINA ☐	SEIZURES OR EPILEPSY ☐	CROHN'S OR ULCERATIVE COLITIS ☐
HEART ATTACK(S) ☐	STROKE OR NUMBNESS ☐	NAUSEA ☐ VOMITING ☐
PALPITATIONS OR IRREGULAR HEART BEATS ☐	MENINGITIS ,POLIO, PARALYSIS ☐	RECTAL BLEEDING ☐
HIV ☐	BODY PIERCING ☐	OTHER ☐

PLEASE BRING ALL INSURANCE CARDS AND ANY APPLICABLE CO-PAY/REFERRAL WITH YOU AT THE TIME OF YOUR PROCEDURE.