



ENDOSCOPIC SURGICAL CENTRE OF MARYLAND- NORTH, LLC

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Rockville, MD 20850
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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- NORTH 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 <input type="checkbox"/>	ANEMIA <input type="checkbox"/>	DIABETES <input type="checkbox"/> LOW BLOOD SUGAR <input type="checkbox"/>
ASTHMA <input type="checkbox"/>	HIGH BLOOD PRESSURE <input type="checkbox"/>	THYROID TROUBLE <input type="checkbox"/>
PNEUMONIA <input type="checkbox"/>	LOW BLOOD PRESSURE <input type="checkbox"/>	KIDNEY TROUBLE <input type="checkbox"/>
TUBERCULOSIS <input type="checkbox"/>	JAUNDICE, HEPATITIS <input type="checkbox"/>	PHYSICAL DISABILITIES <input type="checkbox"/>
EMPHYSEMA <input type="checkbox"/>	LIVER PROBLEMS <input type="checkbox"/>	HISTORY OF MENTAL ILLNESS <input type="checkbox"/>
SHORTNESS OF BREATH <input type="checkbox"/>	COLON POLYPS <input type="checkbox"/>	H PYLORI <input type="checkbox"/>
DO YOU SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO # PACKS/DAY	COLON CANCER <input type="checkbox"/>	GASTRITIS OR ULCERS <input type="checkbox"/>
RHEUMATIC FEVER OR MITRAL VALVE PROLAPSE <input type="checkbox"/>	BACK PAIN OR INJURY <input type="checkbox"/>	CANCER- GASTRIC <input type="checkbox"/> ESOPHAGEAL <input type="checkbox"/>
CHEST PAIN OR ANGINA <input type="checkbox"/>	SEIZURES OR EPILEPSY <input type="checkbox"/>	CROHN'S OR ULCERATIVE COLITIS <input type="checkbox"/>
HEART ATTACK(S) <input type="checkbox"/>	STROKE OR NUMBNESS <input type="checkbox"/>	NAUSEA <input type="checkbox"/> VOMITING <input type="checkbox"/>
PALPITATIONS OR IRREGULAR HEART BEATS <input type="checkbox"/>	MENINGITIS ,POLIO, PARALYSIS <input type="checkbox"/>	RECTAL BLEEDING <input type="checkbox"/>
HIV <input type="checkbox"/>	BODY PIERCING <input type="checkbox"/>	OTHER <input type="checkbox"/>

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