Middlesex Digestive Health and Endoscopy Center
Pre-Procedure Medical Form

Name: _____
Date of Birth: _____
Height: _____ Weight: _____
Ethnicity: _____
Primary Language: English / Other _____
Are you hearing impaired? Yes / No
Do you request an interpreter / translator? Yes / No
If yes, please circle for: speech / hearing / written material

Do you have a history of:

Cardiac Problems:
Yes No
□ □ High Blood Pressure
□ □ Valve Replacement Date of surgery: _____
□ □ Heart Murmur/Palpitations
□ □ Angina/Heart Attack Date of: _____
□ □ Pacemaker Date of placement: _____
□ □ AICD (defibrillator) Date of placement: _____
□ □ Bypass or angioplasty Date of surgery: _____
□ □ Swelling of Extremities
□ □ High Cholesterol: _____

Respiratory Problems:
Yes No
□ □ Asthma
□ □ Sleep Apnea
Other: _____

Kidney/Prostate Problems
Yes No
□ □ Kidney Disease
Men Only:
□ □ Prostate Enlargement
□ □ Prostate Cancer
Other: _____

Liver/Gallbladder Problems:
Yes No
□ □ Hepatitis A B C
□ □ Cirrhosis/Liver Disease
□ □ Gallbladder Disease/Surgery
□ □ Recreational Drug Use
□ □ Alcohol Use: Amt _____
□ □ Smoker: Amt _____
Present ___ Past ___

Neurological Problems:
□ □ Stroke
□ □ Seizure
□ □ Headache
□ □ Dizziness
□ □ TIA

Blood Disorders:
Yes No
□ □ Anemia
□ □ Clotting Disorders
□ □ Bruising
Other: _____

Endocrine Problems:
Yes No
□ □ Diabetes◦ Insulin◦ Oral◦ Diet
□ □ Thyroid Problems

Orthopedic Problems:
Yes No
□ □ Arthritis _____
□ □ Joint Replacement _____
□ □ Metal pins, rods, plates: _____

Mental Status:
Yes No
□ □ Depression
□ □ Confusion
□ Anxiety/Panic Disorders

Women Only:
Yes No
□ □ Hysterectomy
□ □ Mastectomy/Lumpectomy R L
□ □ Are you pregnant? LMP _____

GI Problems:
Yes No
□ □ Family History of Colon Cancer
Relationship: _____
□ □ Personal History of Colon Cancer
□ □ Family History of Colon Polyps
Relationship: _____
□ □ Personal History of Colon Polyps
□ □ Diverticulosis/Diverticulitis
□ □ Colitis/Crohns
□ □ Irritable Bowel Syndrome
□ □ Bleeding
□ □ Constipation/Diarrhea
□ □ Stomach Ulcers
□ □ Barretts Disease
□ □ Weight Loss/Nausea/Vomiting

Aides
□□ Hearing Aid R L
□□ Dentures Full U L
Partial U L

Middlesex Digestive Health and Endoscopy Center
Pre-Procedure Medical Form

Name: _____

Primary Care Physician:

Name: _____

Address: _____
_____

Pharmacy Info:

Name: _____
Address: _____
Phone: _____

Please list any other Medical/Surgical History:

_____
_____

Yes No Do you have a history of requiring antibiotics prior to dental work or medical procedures?
Yes No Do you have a Health Care Proxy? If yes, bring a copy to procedure if available.
Yes No May we leave a message on your home or work answering machine regarding your care?

Latex Allergy? Yes No

Food Allergy? **Please list:** _____
_____

Medication Allergy? **Please list:** _____
_____

Please List ALL Current Medications/Vitamins (Prescriptions and Over the Counter)

Medication	Dose	Frequency	Last Dose
1._____	_____	_____	_____
2. ._____	_____	_____	_____
3. ._____	_____	_____	_____
4. ._____	_____	_____	_____
5. ._____	_____	_____	_____
6. ._____	_____	_____	_____
7. ._____	_____	_____	_____
8. ._____	_____	_____	_____
9. ._____	_____	_____	_____
10. ._____	_____	_____	_____
11. ._____	_____	_____	_____

Patient Signature: _____ Date: _____

This information has been reviewed and updated with the patient just prior to the procedure