Raleigh Endoscopy Center Patient Health History Sheet:

Please fax or mail this form to the endoscopy center location to which you have been assigned (listed below)

at least 2 weeks prior to exam date

Locations:

Main: **2417 Atrium Dr. (Fax) 919-791-2061** **North:** **8300 Health Park (Fax)919-256-7981** **Cary:** **1505 SW Cary Parkway (Fax)919-792-3061**

Patient Name________________________________ Date of Birth__________ Procedure Date__________

Primary Care Physician____________________________ Height__________ Weight________________

******A RESPONISIBLE ADULT/DRIVER MUST REMAIN WITH YOU AT THE ENDOSCOPY CENTER AT ALL TIMES******

Please List Below any **Allergies/Sensitivities** to Medication, Materials, Food and Environmental factors and reaction:

Name and Reaction:

1.________________________________ 4.____________________________ 7.________________________

2.________________________________ 5.____________________________ 8.________________________

3.________________________________ 6.____________________________ 9.________________________

MEDICATIONS: LIST ALL (PRESCRIPTION, NON PRESCRIPTION, SUPPLEMENTS & VITAMINS)

MEDICATION NAME	DOSE TAKEN	FREQUENCY	REASON TAKEN
1.____________________________	________	_______	____________________________________
2. ____________________________	________	_______	____________________________________
3. ____________________________	________	_______	____________________________________
4. ____________________________	________	_______	____________________________________
5. ____________________________	________	_______	____________________________________
6. ____________________________	________	_______	____________________________________
7. ____________________________	________	_______	____________________________________
8. ____________________________	________	_______	____________________________________
9. ____________________________	________	_______	____________________________________
10. Do you take a blood thinner?	Yes	No	Name:________________________________

Do you have any of the following? ***IF YES, contact your GI physician's office for further evaluation***

Trouble Breathing or Anaphylaxis to Latex or Rubber Products?	Yes	No
Oxygen at Home to Help You Breath?	Yes	No
A Letter Stating You Are Difficult to Intubate?	Yes	No
An Implanted AICD for Your Heart?	Yes	No
Currently Pregnant or Breast Feeding?	Yes	No
Currently on Dialysis?	Yes	No
Problems with Anesthesia (if so explain)	Yes	No ________________________

Have You Ever Been Diagnosed With the Following: ***(Please Circle if You Have Had or Currently Have?)***

Congestive Heart Failure	Colon Cancer	Seizures (date of last) ____________________
Irregular Heart Beats	Cirrhosis	Stroke/TIA/CVA (date of last) ______________
Chest Pain/Angina	Liver Disease	Infectious Diseases (type)_________________
Heart Attack (Date)________	Hepatitis(type)_______	Bleeding/Clotting Disorder (type)____________
Heart Stents (number) _____	Colostomy Bag	Cancer(type) __________________________
Shortness of Breath	Colitis/Crohns	Chemotherapy or Radiation: Dates___________
Sleep Apnea (CPAP setting) ____	Anemia	Shingles
COPD	C. Difficle	HIV/AIDS
Kidney Failure	Diabetes	High Blood Pressure

Do you Smoke/chew tobacco? _____ **If Yes**, Please **Do NOT** smoke/chew on the day of your procedure

Drink Alcohol? _____# of drinks/week______ Other/Misc.: (please list) ____

Surgeries: Please List All Major Surgeries

1.____ 4.____

2.____ 5.____

3.____ 6.____