NORTH SHORE ENDOSCOPY CENTER PATIENT MEDICAL HISTORY

WEIGHT: ________ **lbs.** **HEIGHT:** __________

DRUG ALLERGIES: NONE Please List: ____

Egg allergy Yes No Soy allergy: Yes No Latex allergy: Yes No

REASON FOR PROCEDURE: (PLEASE CIRCLE ALL THAT APPLY)

UPPER ENDOSCOPY: Abdominal Pain Barrett's Esophagus Stricture GERD Ulcer Difficulty swallowing Anemia

Other___________________________________

COLONOSCOPY: Screening Abdominal Pain Ulcerative Colitis Cohn's IBS Diarrhea Constipation Bleeding Anemia

Polyps Diverticulitis/losis History of Colon Cancer Other ____

FAMILY HISTORY: NONE Stomach Cancer Colon Cancer Polyps List Relatives ______________________________

Ever been diagnosed with: Hepatitis YES NO TYPE ____ Cirrhosis

PATIENT HISTORY (Please fill out the form to the best of your ability)

SURGERIES: (PLEASE LIST) ____

____

____

HAVE YOU OR A FAMILY MEMBER EVER HAD ANY PROBLEMS WITH ANESTHESIA? YES NO RELATIVE: ______________________

IMPLANTS:___ CARDIAC PACEMAKER HEART VALVES CARDIAC STENTS EYE LENS JOINT REPLACEMENT: ___ KNEE ___HIP

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER? YES NO IF SO WHAT TYPE: ____________________

TREATMENT AND DATES: CHEMOTHERAPY RADIATION SURGERY

EYE, EAR NOSE OR THROAT ISSUES: NONE GLAUCOMA OTHER: ___ **RESPIRATORY PROBLEMS:** NONE ASTHMA SLEEP APNEA CPAP EMPHYSEMA COPD

CARDIOVASCULAR: (HEART PROBLEMS) NONE HEART DISEASE HEART FAILURE MI HIGH BLOOD PRESSURE ARRHYTHMIA HIGH CHOLESTEROL

STROKE COMMENTS: ____

GENITOURINARY: NO KIDNEY PROBLEMS PROSTATE

PREG.TEST OFFERED: **REFUSED / WAIVER SIGNED _____**

BLOOD DISORDERS: NONE ANEMIA:

NEUROLOGICAL: NONE SEIZURES OTHER: _____

SOCIAL HISTORY: SMOKE: YES NO AMT.________

ALCOHOL: YES FREQUENCY _______ NO

SOCIAL DRUG USE: YES NO

OB/GYN: POST-MENAPAUSAL DATE OF LAST MENSTRUAL PERIOD __________________

PREGNANCY TEST RESULT: **NEG** **POS**

PSYCHIATRIC: NONE DEPRESSION ANXIETY

MUSCULOSKELETAL: NONE ARTHRITIS FIBROMYALGIA OTHER

ENDOCRINE: ___ NONE ___THYROID ___DIABETES * **If diabetic please check your blood sugar prior to coming**

* HOME FBS IF TAKEN BY PATIENT________________

* NURSE TO FILL OUT: FBS ____ LOT# _____________ EXP. DATE_______

MEDICATIONS AND SUPPLEMENTS: ****** PLEASE LIST ALL MEDICATIONS AND DOSAGES ON THE MEDICATION SHEET PROVIDED ******

****REMINDER TAKE YOUR HEART AND BLOOD PRESSURE MEDICATION WITH A SIP OF WATER ON THE MORNING OF THE PROCEDURE. BRING YOUR INHALERS WITH YOU.**

ASPIRIN, ALEVE OR ADVIL: LAST DOSE TAKEN: __________

COMMENTS: ____

RN SIGNATURE: ______________________________ **REFERRING PHYSICIAN:** ______________________________

ANESTHESIA PHYSICAL EXAM

SYSTEM	DEFERRED	NORMAL
HEENT	___	___
HEART	___	___
LUNGS	___	___
NEUROLOGICAL	___	___
ABDOMEN	___	___
SKELETAL	___	___
INTEGUMENT	___	___

TEETH

__NORMAL	BRIDGES ___
__LOOSE	PARTIALS ___
__MISSING	DENTURES___
__CAPS	CHIPPED ___
__CROWNS	

PHYSICAL STATUS (ASA CLASS)

___**ASA1** Normal healthy

___**ASA2** Mild systemic disease

__A**SA3** Severe systemic disease, restrictive, not life threatening

___**ASA4** Severe systemic with life threatening disease

I have evaluated the risk associated with the planned anesthesia procedure and have determined the patient is an acceptable candidate.

ANESTHESIOLOGIST/CRNA SIGNATURE:________________________________

Revised: 1/2018