Parkway Endoscopy Center
G.I.
Health History

Please complete this questionnaire and ***bring it with you*** the day you are scheduled for your procedure.

NAME: _____

1. What are your symptoms and how long have you had them? _____
   _____
2. Are you allergic to any medications, dye, LATEX or tape? _____
   _____
3. Please list any medications you take: _____
   _____
   _____
4. Have you ever had abnormal bleeding after surgery or after tooth extraction? _____
   _____
5. Please list any operations you have had? _____
   _____
   _____
6. Please mark **"X"** if you have any history of the following:

☐ Heart Disease	☐ Lung Disease	☐ Blood Disorders	☐ Pregnant
☐ Hypertension	☐ Liver Disease	☐ Seizure Disorders	☐ Other _____
☐ Diabetes	☐ Kidney Disease	☐ Sleep Disorders	
☐ Cancer	☐ Mitral Valve Prolapse	☐ Artificial Implants	

Height _____

Weight _____

Smoke ☐ Yes ☐ No Alcohol ☐ Yes ☐ No

Patient:
DOB: Age:
Physician: **Dr.**
Date of Procedure: