Middlesex Digestive Health and Endoscopy Center
Pre-Procedure Medical Form

Name: _____ Date of Birth:_____

Height: _____ Weight:_____

Ethnicity: _____ Primary Language:_____

Are you hearing impaired: Yes / No

Do you request for an interpreter/translator?: Yes / No

If Yes, please circle for: speech / hearing / written material

For nursing use only:

R: _____

Cls:_____ Pa: _____

Egd: _____ F: _____

P: _____ Zofran:_____ S:_____

Npo: _____ A: _____

Do you have a history of:

Cardiac Problems:

Yes	No	
☐	☐	High Blood Pressure
☐	☐	Valve Replacement- Date of surgery: _____
☐	☐	Arrhythmia / AFib / Heart Murmur / Palpitations
☐	☐	Angina/Heart Attack (MI) : Date of: _____
☐	☐	Pacemaker: Date of surgery/checked:_____
☐	☐	Defibrillator (AICD)- call our office
☐	☐	CABG, Bypass, Angioplasty: Date of: _____
☐	☐	Swelling of extremities/edema
☐	☐	High Cholesterol

Respiratory Problems:

☐	☐	Asthma, COPD, Emphysema, Other:_____
☐	☐	Sleep Apnea: Do you use a cpap?: Yes No
☐	☐	Difficult airway / history of tracheotomy- call office

GI Problems:

☐	☐	Family History of Colon Cancer. Relationship: _____
☐	☐	Family History of Colon Polyps Relationship: _____
☐	☐	Family History of Crohns Disease / Ulcerative Colitis? Colitis? Relationship: _____
☐	☐	Personal History of Colon Cancer
☐	☐	Personal History of Polyps
☐	☐	Diverticulosis and/or Diverticulitis
☐	☐	Crohns Disease, Colitis, or Celiac Disease
☐	☐	Irritable Bowel Syndrome
☐	☐	Bleeding
☐	☐	Constipation or Diarrhea
☐	☐	Stomach or Esophageal Ulcers
☐	☐	Barretts Disease, History of Eosinophilic Esophagitis
☐	☐	Weight Loss/Nausea/Vomiting

Liver/ Gallbladder Problems:

☐	☐	Hepatitis A B C
☐	☐	Cirrosis/Liver Disease
☐	☐	Gallbladder Disease/ Surgery

Endocrine Problems:

Yes	No	
☐	☐	Diabetes- Insulin Oral Diet
☐	☐	Thyroid Problems: _____

Kidney/Prostate Problems:

☐	☐	Kidney Disease

Men Only:

☐	☐	Prostate CA
☐	☐	Prostate Enlargement/ BPH

Neurological problems:

☐	☐	Stroke
☐	☐	Seizure
☐	☐	Headache/Migraine
☐	☐	Transient Ischemic Attack (TIA)
☐	☐	Vertigo/Balance Issues/ Dizziness

Orthopedic / Musculoskeletal Problems

☐	☐	Arthritis
☐	☐	Joint Replacement:_____

Mental Status:

☐	☐	Depression
☐	☐	Anxiety/ Panic Disorders
☐	☐	Confusion

Blood Disorders:

☐	☐	Anemia
☐	☐	Clotting Disorders/or Anticoagulant use
☐	☐	Bruises easily

Women Only:

☐	☐	Hysterectomy
☐	☐	Mastectomy/ Lumpectomy: R L
☐	☐	Are you pregnant? LMP:_____

Do you have a history of Cancer?

☐ ☐

Type: _____

Treatment: _____

Name: _____

Primary Care Physician: _____

Primary Care Physician Address: _____

Social History:			Any Metals inside your body/Aides?		
Yes	No		Yes	No	
☐	☐	Recreational Drug use: Amt: _____	☐	☐	Metal pins/rods/plates? Location: _____
☐	☐	Alcohol Use: Amt: _____	☐	☐	Dentures: Full: U L Partial: U L
☐	☐	Smoker: Amt: _____	☐	☐	Hearing Aid: R L - Are they in place? Yes No

PLEASE LIST YOUR SURGICAL HISTORY AND ANY OTHER MEDICAL HISTORY:

_____

_____

_____

1. Do you have a history of requiring antibiotics prior to dental work or medical procedures? YES NO
2. Do you have a healthcare proxy? If yes please bring a copy to your procedure if available. YES NO
3. May we leave a message on your home or work answering machine regarding your care? YES NO

ALLERGIES (please list any allergies and the reactions you experienced)

Food Allergy: Yes No Please list:_____

Medication Allergy: Yes No Please list:_____

_____

Adhesive Sensitivity: Yes No **Egg Allergy**: Yes No **Iodine Allergy:** Yes No **Latex Allergy:** Yes No

PLEASE LIST ALL OF YOUR MEDICATIONS/VITAMINS (prescriptions and over the counter)

	MEDICATION	DOSEAGE	FREQUENCY	LAST DOSE
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Did you take Zofran Prior to your procedure? Yes No