Woodburn Endoscopy Center

Patient Provided Health / History Information

Patient Label Here

Patient Name _____ Referring Physician _____

Reason for Your Procedure Today: _____

Date of Birth: _____ Age: _____ Height _____ Weight _____

Name & Relationship of the Person Driving You Home _____

This person is: Waiting _____ Will Return to Office _____ Phone Number(s) _____

Have You Ever Had Any of the Following Medical Conditions:

	Yes	No		Yes	No		Yes	No
Asthma			IBS, Colitis or Crohn's			Thyroid Problems		
Bronchitis			History of Polyps			Migraine Headaches		
Sleep Apnea			Constipation / Diarrhea			Seizures		
Tuberculosis			Hemorrhoids			Kidney Failure / Disease		
COPD			Ulcers / Gastritis			HIV / AIDS		
High Blood Pressure			Reflux / GERD			Depression / Anxiety		
High Cholesterol			Esophagitis / Hiatal Hernia			Diabetes: Type I / Type 2 ?		
Heart Attack			Barretts Esophagus					
Coronary Artery Disease			Liver Disease / Cirrhosis			Could You Be Pregnant?		
Congestive Heart Failure			Hepatitis [A B or C ?]			Date of Last Period: _____		
Heart Murmur			Anemia					
Mitral Valve Prolapse			Bleeding Tendency			Cancer: (If Yes, Type ?)		
Irregular Heartbeat			Arthritis					
Stroke			Prosthetic Joints / Implants					

	Yes	No
Family Hx of Polyps ?		
Family Hx of Colon Cancer ?		
Family Hx of stomach / Upper GI Problems ?		
Do you have any other medical problems not mentioned on this form ?		
Have you ever had any problems when given anesthesia ?		

Please Provide Details on Any Conditions Checked Above:

Past Hospitalizations and/or Surgeries *(include dates)*:

Social History: Alcohol Use: Y ___ N ___ Approximately _____# of drinks per day / week / month / year

Drug Use: Y ___ N ___ Type / Frequency of Use _____

Tobacco Use: Y ___ N ___ Quit in _____ Current packs per day _____

Allergies: Latex / Plastic _____

Food _____

Medicine _____

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **Date:** _____

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