## GI LAB HEALTH & HISTORY INFORMATION

Date _____ Name _____ Nickname _____ Procedure _____
Primary Care Physician _____ Gastroenterologist _____
Height _____ Weight _____ Why are we doing the procedure today? _____

***Medical Surgical History***

Have you ever had or used any of the following: (check all that apply)

- ☐ Advance Health Care Directive
  Would you like information?
  ☐ Yes ☐ Info Given ☐ No
- ☐ Diarrhea
- ☐ Constipation
- ☐ Colon disease such as: polyps, diverticulosis IBS, colitis, Crohn's, obstruction, cancer
- ☐ Use of laxatives, enemas, or stool softeners
- ☐ Ostomy
- ☐ Bloody stools
- ☐ Trouble Swallowing
- ☐ Ulcer
- ☐ Hiatal Hernia
- ☐ Cirrhosis
- ☐ Hepatitis A, B or C
- ☐ Gallbladder problems
- ☐ Jaundice
- ☐ Asthma
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ COPD
- ☐ Emphysema
- ☐ Sleep apnea
- ☐ Oxygen day and/or night
  How many liters? _____
- ☐ CPAP/BIPAP machine
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Heart Murmur
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Angioplasty
- ☐ Pacemaker/Defibrillator
- ☐ Open heart surgery (CABG)
- ☐ Heart Valve Replacement
- ☐ Stents
  Location_____
- ☐ Kidney dialysis
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Incontinence of urine
- ☐ Seizures
- ☐ Stroke
- ☐ Paralysis
  Location _____
- ☐ Loss of sensation
  Location _____
- ☐ Sexually Transmitted Disease
- ☐ HIV/AIDS
- ☐ Arthritis
- ☐ Eye Problems
- ☐ Diabetes
  - ☐ Diet controlled
  - ☐ Oral medication
  - ☐ Insulin dependent
- ☐ Cancer
  Location _____
- ☐ Mastectomy
  - ☐ Right Side
  - ☐ Left Side
- ☐ Date of last menstrual period _____
- ☐ I require antibiotics before going to the dentist because _____
  _____
  _____
- Glasses: ☐Yes ☐No
- Contacts: ☐Yes ☐No
- Dentures: ☐ Yes ☐ No
  ☐ Uppers ☐ Lowers
  ☐ Partials
- Hearing Aids: ☐Yes ☐No
  ☐Right ☐Left

**Do family members have a history of :**

☐Heart disease ☐Cancer
☐GI disorders ☐Diabetes

***Latex Allergy Screen:***

Are you allergic to latex?
☐ No ☐ Yes
Have you ever been tested for latex allergy?
☐ No ☐ Yes
Are you allergic to bananas, avocados, kiwi fruit, or chestnuts?
☐ No ☐ Yes
Do you have asthma, hay fever, eczema, or problems with rashes?
☐ No ☐ Yes
Do you have swelling, itching, hives, or other symptoms following contact with balloons, rubber gloves or objects, a dental exam, vaginal or rectal exam, or use of a diaphragm or condom?
☐ No ☐ Yes
Do you have unexplained respiratory distress, rapid heartbeat, or other anaphylactic episodes?
☐ No ☐ Yes
If allergic to latex, band on ☐ Yes

***List all surgeries and/or hospitalizations:***_____
_____
_____
_____

***Medication Allergies:*** List all allergies and reactions: _____
_____
_____
_____

***Medications (Include over the counter medications and vitamins and doses)***
_____
_____
_____

***Social History:*** Do you . . .
drink alcohol? ☐No Quit date _____ ☐Yes # of drinks_____ per _____
smoke tobacco? ☐No Quit date _____ ☐Yes # of years ____ packs/day ____
chew tobacco? ☐No Quit date _____ ☐Yes # of years ____ frequency_____
use recreational drugs? ☐ No Quit date _____
☐ Yes Type _____ Frequency _____

**Pain:** Are you having any pain today? ☐ No ☐ Yes
If so, where, and describe it using the 1-10 scale:
_____

Patient Signature _____ Nurse Signature _____

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PLACE PATIENT LABEL HERE