# Salt Lake Endoscopy Center
# Patient Medical History Form

Patient's Name:_____Age:_____Birthday:_____

Sex: ☐ Male ☐ Female **Weight** :_____Height:_____

**First & Last Name of Primary Care Physician**: _____

Patient's Driver: _____Relationship:_____Telephone:_____
**Permission to disclose results of exam to your driver? ☐ Yes ☐ No**

Emergency Contact (If different from above):_____Telephone:_____

**Advance Directives (Living Will): ☐ Yes ☐ No ***SLEC does not honor Advance Directives***

**Procedure:** ☐ Colonoscopy ☐ EGD ☐ Dilation ☐ Flexible Sigmoid ☐ Esophageal Motility ☐ pH Bravo study
**What symptoms, if any, have brought you to the clinic today?** _____

The day after your procedure, Salt Lake Endoscopy Center will call to see how you are doing. If there is no answer, do you give permission for us to leave a message? **☐ No ☐ Yes, number #_____**

**Salt Lake Endoscopy Center values your opinion of your experience. Would you like the survey in paper form or would you like it emailed to you? ☐ paper, ☐ email address: _____**

Did you receive a copy of your Patient Rights prior to coming to your procedure? ☐ Yes ☐ No

**Do you** have dentures, or loose teeth? ☐ Yes ☐ No **Do you** have Glasses? ☐ Yes ☐ No
**Do you** require assistive devices such as: Wheelchair ☐ Yes ☐ No Walker ☐ Yes ☐ No

Do you smoke? ☐ No ☐ Yes Drink Alcohol? ☐ No ☐ Yes_____/wk
Use Recreational drugs? ☐ No ☐ Yes_____

Have you or a blood relative had an adverse reaction to anesthesia or sedation medication? ☐ No ☐ Yes_____
**FEMALE PATIENTS ONLY**: Are you on birth control? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No
Is there any chance you could be pregnant? ☐ Yes ☐ No
Have you had a hysterectomy? ☐ Yes ☐ No

***Do you have or ever had any of the following:***
☐ Sleep Apnea
☐ Cancer _____(type)
☐ Heart Valve Replacement Surgery
☐ Coronary Artery Bypass Surgery (CABG)
☐ Heart Disease (CHF, Heart Attack, Congenital Heart Defect)
☐ Diabetes
☐ Liver Disease/Hepatitis ☐ A ☐ B ☐ C ☐ Unknown
☐ HIV/AIDS
☐ Lung Disease (Asthma, Emphysema, COPD)
☐ History of Rheumatic Fever
☐ Bleeding Problems (Anemia, Clotting Disorders)
☐ Hypertension (High Blood Pressure)

*Surgeries:* ☐ Abdominal ☐ Appendix Removal ☐ Hernia Repair ☐ Gallbladder
*List any other surgeries you have had:*_____