ST. JOSEPH HOSPITAL ENDOSCOPY

YOUR NAME _____

DRUG or **FOOD ALLERGIES** : ☐ No ☐ Yes please list _____

Personal Medical History: Please check all that apply and list any additional medical information below____

☐ High Blood Pressure	☐ Sleep Apnea	☐ Seizures	☐ Liver Disease
☐ High Cholesterol	CPAP__ BIPAP___	☐ Back Pain/injury	☐ Kidney Disease
☐ Anemia	☐ Snores at night	☐ Cancer,	☐ Bleeding Problems
☐ Heart Attack	☐ COPD	type_____	☐ Falls in the past year
☐ Heart Problem*	☐ Asthma	☐ Diabetes	☐ Dentures Upper / lower/
If yes describe:	☐ GERD/Heartburn	☐ Low Thyroid	Partial (please circle)
_____	☐ Stroke ☐ TIA	☐ High Thyroid	

Surgery:

☐ Appendectomy	☐ Gallbladder	☐ Hysterectomy	☐ C-Section	☐ Hernia
☐ Tonsillectomy	☐ Heart	☐ Abdominal Surgery	☐ Eye Surgery	☐ Other:
☐ Pacemaker/Defibrillator	☐ Joint Replacement, location_____			☐ Other:

When did you **DRINK FLUIDS** last including, your Prep: _____

Do you have any **metal in the body** (not teeth)? ☐ No ☐ Yes If yes where?_____

Females - Last **Menstrual Period**: _____ Any chance you could be pregnant? ☐ No ☐ Yes

Community Health Question- (unrelated to your procedure!) – Have you completed a living will or health care proxy? This is a formal document naming someone to make decisions for you if you are unable to do so.

☐ Yes ☐ No If no would you like **more information**? ☐ Yes ☐ No

If you have a list of your medications, ***please just GIVE it to the nurse - **DO NOT COMPLETE BELOW****

INCLUDE over the counter medications and herbals PLEASE.

Medication	Dose	How Often	**Last Dose**	Medication	Dose	How Often	**Last Dose**

Name of person taking you home today?_____Phone Number _____

What Items do you have with you TODAY for the procedure? If you have any of these walking in we want to ensure you have them walking out! Keep valuables at home please. Circle all that apply

Dentures: full partial upper lower Glasses Hearing aids Cane Walker

Personal Wheelchair Other:_____