****Please fill out this page and give it to the Day Surgery Nurse the day of your procedure.****

Please use the back of this sheet for medication list

Name:_____Date of Birth_____

What are you having done today:_____

Height: _____ Weight: _____

Family Doctor: _____

Referring Doctor: _____

ALLERGIES (medication/food)

_____

_____

_____

_____

_____

_____

Last colonoscopy, when & where:

_____

Last EGD, when & where:

_____

Circle surgeries you have had:

Appendectomy
Bowel
C-Section
Endometrial ablation
Gallbladder
Heart
Heart Valve Replacement
Hernia repair
Hysterectomy
Laparoscopy
Mastectomy
Pacemaker/Defibrillator
Thyroid
Tubal
Other: _____

_____

Circle medical problems that you have:

Anemia
Asthma/COPD
Cancer—What type?

_____

Diabetes
Heart disease
Hepatitis/Liver problems
Hiatal hernia
High Blood Pressure
High Cholesterol
Irritable Bowel Syndrome (IBS)
Kidney problems
Mitral Valve Prolapse
Seizures
Sleep apnea
Stroke
Thyroid Disease
Ulcers
Other:_____

_____

LMP: _____

Prosthesis/metal anywhere in your body: _____

_____

_____

Circle yes or no

Yes No --- Do you use nicotine? If yes, what kind? _____ How much? _____
Yes No --- Do you drink alcohol? If yes, what kind? _____ How much? _____
Yes No --- Family history of colon/stomach/esophageal cancer? If yes, type: _____
Yes No --- Do you have a living will or advance directive for medical purposes? Please bring a copy.
Yes No --- Have you been out of the U.S. in the past 3 weeks?

Circle the ones you wear:

Dentures Partials Retainers Glasses Contacts

Medication name	Dosage	How often you take it