Patient Label

LAKESIDE ENDOSCOPY CENTER, LLC
Patient History

Reason for Visit (Check all that apply)

___Screening Colonoscopy
___Family history colon cancer
___Personal history colon polyps / cancer
___Personal history Crohn's disease
___Personal history ulcerative colitis
___Blood in stool / rectal bleeding
___Reflux
___Difficulty swallowing
___Nausea / vomiting
___Bloating / gas / stomach discomfort
___Increased appetite
___Decreased appetite
___Recent weight change
Gain___lbs / Loss___lbs
Over how much time_______________
___Pain / Location____________________

1 2 3 4 5 6 7 8 9 10
Very mild Severe

Onset/Duration______________________________
Type of Pain________________________________
Triggers/Relief______________________________
___Other ______________________________
____
____

Medical History (Check all that apply)

___Heart disease___________________________
___Liver disease ___________________________
___Stroke
___Blood pressure ___High ___Low
___Thyroid________________________________
___Diabetes
___Cancer / Type___________________________
___Current pregnancy
___Lung disease____________________________
___Kidneys ________________________________
___Seizures / Date of last___________________
___Arthritis_______________________________
___Hearing difficulty
___Vision difficulty ________________________
___Other__________________________________

Have you had a sigmoidoscopy or barium enema? ___No ___Yes Date _______________

Last medical examination_____________________

Tobacco use ___No ___Yes
Drink alcohol ___No ___Yes ___Rarely
Caffeine ___No ___Yes ___Rarely

Allergies / Reactions they cause

____
____
____

Prior Anesthesia Problems

___No ___Yes
Explain____
____

Past Surgeries / Hospitalizations

____
____
____
____
____

Current Medications

Please fill out the Home Medication List form and **bring it with you to your procedure.** If you did not receive a form please bring a list of all your medications and dosages.

____
Patient Signature

____
Date

____
Nurse Signature Indicating Review

____
Date