South Denver Gastroenterology, P.C.

Comprehensive Medical History and Physical

Please do **not** complete this form more than 30 days prior to your procedure

PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

Primary Care Physician: _____ Referred By: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Decline ☐ Unknown

Race: ☐ American Indian or Alaskan Native ☐ Black or African American

☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Patient Decline ☐ Unknown ☐ Other

Allergies/Reaction: **Y N** _____

_____

Latex Allergy/Reaction: **Y N** _____

MEDICAL HISTORY

Please indicate if you have or recently had any of the following symptoms or problems (circle Yes or No)

GENERAL

Y N Pregnant (currently)
Y N Breast Surgery
__ Left __Right __Both
Y N Problems with Anesthesia/narcotics
Y N Weight loss
Y N Artificial Joints

HEART

Y N Chest Pain
Y N Cardiac Disease
Y N High blood pressure
Y N Heart infections
Y N Artificial heart valve
Y N Pacemaker/Defibrillator

HEMATOLOGIC

Y N Anemia
Y N Blood thinners (coumadin, etc)

NEUROLOGIC

Y N Stroke/other major neurologic problem

LUNG

Y N Lung disease
Y N Shortness of breath or cough
Y N Sleep Apnea
Y N Oxygen at home, ____liters/min

OTHER

Y N Diabetes

GASTROINTESTINAL

Y N Difficulty swallowing food sticking
Y N Change in bowel habits
Y N History of colon polyps (self)
Y N History of colon cancer (self)
Y N Family history polyps/cancer
Y N Liver disease
Y N History of Colonoscopy
date: _____
Y N Crohn's
Y N Ulcerative Colitis
Y N Barrett's Esophagus
Y N GERD (reflux)
Y N Rectal Bleeding

List of Major Surgeries/Hospitalizations: _____None

_____

_____

Y N Alcohol Describe: _____ **Y N** Drug/Substance Use Describe: _____

Y N History of Cigarette/Tobacco Use Describe: _____

Current Prescribed Medications: _____None

DRUG	STRENGTH	HOW OFTEN?	DATE LAST DOSE TAKEN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Over the Counter/ Nonprescription (Aspirin, Advil, Ibuprofen, Tylenol, Aleve, Nuprin, Motrin) or Vitamins, Herbs, or Minerals: _____ None _____

Patient Signature: _____

Physician Signature: _____Nurse Signature: _____