

## NORTHSIDE HOSPITAL GI Patient History Form

Ex M F Date of Birth Height Weight Ibs rocedure name  Training Language Prefered Language  To you need an interpreter?  The region of Patient's driver  The you pregnant? Yes No Location? Level of pain (1-10)  To you have any wision impairments? Including glasses/contacts? Yes No If yes, explain  To you have any denture, caps, broken or loose teeth? Yes No you wou whave any denture, caps, broken or loose teeth? Yes No you wou whave implants or prostheses? Yes No you wou whave implants or prostheses? Yes No If yes, explain  To you have any back, neck, or jaw problems? Yes No you have any musculoskeletal conditions? Yes No you have asthma? Yes, No you have asthma? Yes, No you have any musculoskeletal conditions? Yes No you woo woo wooke wearn musculoskeletal conditions? Yes No you have any musculoskeletal conditions? Yes No you woo wooke wou wooke wooken wookeletal conditions? Yes No you whave any musculoskeletal conditions? Yes No you wooke wooken wookeletal conditions? Yes No you wooken wooken wooken wookeletal conditions? Yes No you wooken wook	PATIENT NAME		DATE	
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If yes, explain o you have asthma? Ves No o you have bronchitis or COPD? Yes No	If yes, explain			
o you have asthma?  O you have bronchitis or COPD?  Yes No	Do you have any musculoskeletal conditions?			No
o you have bronchitis or COPD?  Yes No	If yes, explain			
	Do you have asthma?		Yes	No
o you ever experience shortness of breath?	Do you have bronchitis or COPD?		Yes	No
	Yes	No		
If yes, explain				
o you have sleep apnea? Yes No	Do you have sleep apnea?		Yes	No

Do you use a nebulizer, breathing machine or oxygen at home?		No
If yes, explain	Yes	
Do you have high blood pressure?	Yes	No
Do you have congestive heart failure?	Yes	No
Do you have an irregular heartbeat?	Yes	No
If yes, explain		
Have you had a heart attack?	Yes	No
Have you had heart surgery/stent/catheter placement?	Yes	No
Do you have a pacemaker/defibrillator?	Yes	No
Have you ever had a stroke or TIA?	Yes	No
Have you ever had a seizure?	Yes	No
Do you have any paralysis?	Yes	No
If yes, explain	100	
Have you ever been diagnosed with cancer?	Yes	No
If yes, explain		
Do you have diabetes?	Yes	No
Diet controlled? Yes No Insulin Controlled?	Yes	No
Are you hypothyroid?	Yes	No
Are you hyperthyroid?	Yes	No
Do you have ulcers or hiatal hernia?	Yes	No
Do you have acid reflux?	Yes	No
Do you have gall bladder disease?	Yes	No
Have you had GI/rectal bleeding?	Yes	No
Do you have jaundice?	Yes	No
Do you have hepatitis?	Yes	No
Do you have cirrhosis of the liver?	Yes	No
Do you have any kidney conditions?	Yes	No
If yes, explain		
Are you on dialysis?	Yes	No
Do you have any rashes?	Yes	No
If yes, explain		
Do you have any bruises?	Yes	No

If yes, explain		
Do you have any burns?	Yes	No
If yes, explain		
Do you have any wounds?	Yes	No
If yes, explain		
Do you have any tape problems?	Yes	No
If yes, explain		
Do you have sickle cell disease?	Yes	No
Do you have any blood clots?	Yes	No
Are you taking blood thinners?	Yes	No
Did your doctor instruct you to stop taking your blood thinners before your procedure?	Yes	No
Do you take ibuprofen regularly?	Yes	No
Did your doctor instruct you to stop taking your aspirin/ibuprofen before your procedure?	Yes	No
Have you ever been diagnosed with TB?	Yes	No
Have you ever been diagnosed with MRSA?	Yes	No
Have you ever been diagnosed with VRE?	Yes	No
Have you been diagnosed with HIV/AIDS?	Yes	No
Have you traveled outside the U.S. recently?	Yes	No
If yes, when/where?		
Have you ever been treated for depression?	Yes	No
Have you been diagnosed with an anxiety/panic disorder?	Yes	No
Have you ever been treated for substance abuse?	Yes	No

## **SURGICAL HISTORY**

Operation/Procedure	Anesthesia	Complications	Year

## **CURRENT MEDICATIONS (prescribed, over-the-counter, herbal, steroids, diet pills)**

Medication	Dosage	How often?