westside
GASTROENTEROLOGY
consultants

Pre-Procedure History Update Form

Name _____ Date of Birth _____

Patient Medical History-Circle all that apply, write in additional information if needed

Diabetes High Blood Pressure High Cholesterol Heart Attack Stroke

Hear Valve abnormality Sleep Apnea Kidney Disease Cancer (list type) _____

Blood Transfusion Bleeding Abnormality Heartburn/GERD Colon Polyps

Have you been told to take antibiotics before dental or GI procedures YES NO (if yes, list reason _____)

Other Health Problems: _____

_____

Past Surgical History _____

_____

Allergies- List medicine name and reaction _____

_____

Medications- Please list dose and number of times taken a day. Include vitamins, herbs, over the counter medication, aspirin. Attach list if more space is needed.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Family History of Intestinal or Liver Disease- List relation and type of disease: _____

_____

Social History

Tobacco Use: Y/N ___ Packs/day for ___ years

Alcohol Use: Y/N ___ Amount per day/week/month

Other Drug Use _____

Date form completed _____