MaineGeneral Gastroenterology
Alfond Center for Health
35 Medical Center Parkway
Augusta, ME 04330
Phone# 207.621-4600

Pre-Endoscopy Health History

MaineGeneral Medical Center

Name_____ Date of Birth_____ Height_____ Weight_____

Family Physician_____ Referring Physician_____

Procedure -

Health History (Please check all that apply)

Cardiovascular - any history of heart problems? ☐ NO ☐ YES **(please check all that apply)**
☐ Chest pain/angina ☐ Heart attack – date: _____ ☐ Atrial fibrillation (A-fib)
☐ Heart murmur ☐ High blood pressure ☐ Heart failure/Congestive heart failure

☐ Pacemaker and/or ICD - date of insertion _____Device: ☐ Medtronic ☐ Guidant ☐ St. Jude ☐ Dupont
☐ Defibrillator device: _____
☐ Recent heart studies (ECHO, stress test, etc.) please list with date of test _____
_____

Hematological – any history of bleeding problems? ☐ NO ☐ YES **(please check all that apply)**
☐ Blood thinners

Respiratory – any history of respiratory problems? ☐ NO ☐ YES **(please check all that apply)**
☐ Lung disease ☐ Asthma and wheezing ☐ COPD/Emphysema
☐ Snoring ☐ Stop breathing while asleep or have been told I do
☐ Sleep apnea (diagnosed by sleep study)
Do you use a CPAP? ☐ NO ☐ YES
Do you use oxygen at home? ☐ NO ☐ YES

Neurological – any history of neurological problems? ☐ NO ☐ YES **(please check all that apply)**
☐ Seizures ☐ TIA/CVA ☐ Stroke ☐ Depression ☐ Multiple Sclerosis ☐ Parkinson's

Mental Health History ☐ NO ☐ YES **(please check all that apply)**
☐ PTSD ☐ Bipolar Disorder ☐ Schizophrenia ☐ Anxiety/panic attacks ☐ Sexual abuse

Diabetes – any history of problems? ☐ NO ☐ YES **(please check all that apply)**
☐ Diabetes ☐ Insulin requiring ☐ Non-Insulin requiring

Musculoskeletal – any history of problems? ☐ NO ☐ YES **(please check all that apply)**
☐ Limited mobility (use of assistive devices, walker wheelchair) ☐ Limited range of motion with neck or jaw (circle one)
☐ Dental concerns (loose, chipped, missing teeth)

Gastrointestinal – any history of problems? ☐ NO ☐ YES **(please check all that apply)**
☐ Heartburn, indigestion, reflux ☐ Hiatal hernia ☐ Ulcers ☐ Difficulty swallowing ☐ Esophageal stricture
☐ Recent change in stool habits ☐ Frequent diarrhea ☐ Constipation ☐ Hemorrhoids ☐ Abdominal pain
☐ Pain or bleeding with bowel movements ☐ Colitis ☐ Diverticulitis ☐ IBS (Irritable Bowel Syndrome)
☐ Polyps ☐ Cancer, please describe _____
☐ Liver problems ☐ Hepatitis B ☐ Hepatitis C

Genitourinary – any history of problems? ☐ NO ☐ YES **(please check all that apply)**
☐ Kidney disease ☐ Renal failure ☐ Dialysis

<u>Worksheet Only – Not part of the permanent record</u>

Pre-Endoscopy Health History (cont'd)

Gynecological – Are you pregnant? ☐ NO ☐ YES ☐ I do not know

Infectious disease – Have you ever been told you have any of the following? ☐ MRSA ☐ VRE ☐ C-diff

Social History
Do you use tobacco? ☐ NO ☐ YES Smoke # of packs per day _____ for # of years_____ ☐ Chew
Do you use alcohol? ☐ NO ☐ YES If every day, list amount _____
Do you use recreational/non-prescribed drugs? ☐ NO ☐ YES
Do you use medical marijuana? ☐ NO ☐ YES

Previous Surgery – Please list previous surgeries with approximate dates.

_____
_____
_____

Have you ever had any issues/problems with anesthesia in the past? ☐ NO ☐ YES (**Please describe below**)

_____

Please list all current medications, vitamins, herbal preparations and supplements - PLEASE PRINT
☐ **Please check if you do not take any medications**

MEDICATION	DOSE (mg/pill)	# of times per day	Reason for taking

ALLERGIES – Do you have a latex allergy? ☐ NO ☐ YES
Do you have a medication allergy? ☐ NO ☐ YES **(please list below)**

Medication	Reaction: (hives, rash, nausea, swelling anaphylactic)

FAMILY HISTORY of polyps or gastrointestinal cancer (stomach, colon, throat/esophageal)? ☐ NO ☐ YES
Please list relation (i.e. mother, uncle, etc.), type of gastrointestinal cancer and the age they were diagnosed

_____
_____

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