Name _____ DOB _____

Address _____ patient label here

Daytime Phone _____Home Cell Work (Circle one)

CENTRAL PENN ENDOSCOPY CENTER/CENTRAL PENN GI

MEDICAL HISTORY FORM *Month/Year Last Flu Shot _____ Last Pneumonia Shot _____*

Family MD _____

PRESENT ILLNESS AND DURATION:

1. **SCHEDULED PROCEDURE & DATE:**

   _____

2. If you are under regular medical care, list reason and duration:

3. **Height** _____ **Weight** _____

4. **FEMALE PATIENTS:**
   Date of last menstrual period _____
   Are you now pregnant or is there a possibility you may be pregnant ☐ yes ☐ no

5. **MALE PATIENTS:**
   Prostate disorder ☐ yes ☐ no

6. **LUNG DISEASE:**

Asthma	☐ yes	☐ no
Emphysema	☐ yes	☐ no
Bronchitis	☐ yes	☐ no
Pneumonia	☐ yes	☐ no
Tuberculosis	☐ yes	☐ no
Daily cough	☐ yes	☐ no
Productive cough	☐ yes	☐ no
Shortness of breath	☐ yes	☐ no
Wheezing	☐ yes	☐ no
Are you able to walk up 2 flights of stairs without shortness of breath?	☐ yes	☐ no

7. **TUMORS:**
   Cancer/Malignancy ☐ yes ☐ no
   Treatment Chemo/Surgery/Radiation

8. **CARDIOVASCULAR DISEASE:**

High blood pressure	☐ yes	☐ no
Stent or cardiac surgery (date_____)	☐ yes	☐ no
Abnormal pulse/rhythm	☐ yes	☐ no
Chest pain/tightness	☐ yes	☐ no
Ankle swelling/edema	☐ yes	☐ no
Peripheral vascular disease	☐ yes	☐ no
Elevated cholesterol	☐ yes	☐ no
Circulation problems murmur	☐ yes	☐ no
Angina	☐ yes	☐ no
Palpitations	☐ yes	☐ no
Heart attack	☐ yes	☐ no
History rheumatic fever	☐ yes	☐ no
Echocardiogram (date/place_____)	☐ yes	☐ no
Stress test (date/place _____)	☐ yes	☐ no
Last EKG (date/place _____)		

9. **BLOOD DISORDERS:**

Anemia	☐ yes	☐ no
Abnormal blood count	☐ yes	☐ no
Bleeding tendencies	☐ yes	☐ no

10. **INFECTIOUS DISEASE:**

Hepatitis	☐ yes	☐ no
HIV/AIDS	☐ yes	☐ no
MRSA	☐ yes	☐ no

11. **DIGESTIVE DISORDER:**

History of Ulcer	☐ yes	☐ no
Abdominal pain	☐ yes	☐ no
Change in stool habits	☐ yes	☐ no
Difficulty swallowing	☐ yes	☐ no
Nausea/Vomiting	☐ yes	☐ no
Hiatal hernia/Reflux/Heartburn	☐ yes	☐ no
Rectal Bleeding	☐ yes	☐ no
Liver disease	☐ yes	☐ no
Irritable Bowel Disease/Syndrome	☐ yes	☐ no
Celiac Disease	☐ yes	☐ no
Have you used Reflux/Heartburn Medication in the past?	☐ yes	☐ no

   If so What? _____

12. **KIDNEY/BLADDER DISEASE:**

Kidney infection	☐ yes	☐ no
Pain on urination	☐ yes	☐ no
Kidney failure/Dialysis	☐ yes	☐ no
Blood in urine	☐ yes	☐ no

13. **METABOLIC/ENDOCRINE:**

Diabetes	☐ yes	☐ no
Thyroid disorder	☐ yes	☐ no
Adrenal Problems	☐ yes	☐ no

14. **EYE, EAR, NOSE, & THROAT:**

Hearing problems	☐ yes	☐ no
Glaucoma	☐ yes	☐ no
Dentures/Caps/Appliances	☐ yes	☐ no

15. **NEUROMUSCULAR DISEASE:**

Seizures/Convulsions	☐ yes	☐ no
Stroke/Paralysis/TIA	☐ yes	☐ no
Abnormal muscular weakness	☐ yes	☐ no

16. **PSYCHOLOGICAL:**

Depression	☐ yes	☐ no
Anxiety	☐ yes	☐ no

OVER

Name _____ DOB _____

Address _____ patient label here

Daytime Phone _____Home Cell Work (Circle one)

CENTRAL PENN ENDOSCOPY CENTER/CENTRAL PENN GI

MEDICAL HISTORY FORM

17. BONE/JOINT DISEASE:

TMJ	□ yes	□ no
Back problems/Disc Disease	□ yes	□ no
Arthritis	□ yes	□ no
Joint pain/swelling/warmth	□ yes	□ no
Recent fractured bones	□ yes	□ no
Specify:		
Prolonged Prednisone/Steroid use	□ yes	□ no
Neck mobility/problem	□ yes	□ no

18. OTHER MEDICAL CONDITIONS:

Has your Doctor ever told you that you need antibiotics prior to a procedure □ yes □ no

If yes, Why? _____

19. SOCIAL HISTORY:

Do you live alone? □ yes □ no

Do you consume alcohol regularly? □ yes □ no

If yes, how much daily? _____

Have you ever abused any drugs? □ yes □ no

Please specify:

20. TOBACCO HISTORY:

Have you ever smoked regularly?

□ yes □ no □ now

Quantity:____ packs/day and duration_____years

If you've quit, when did you last smoke? _____

21. ANESTHESIA:

Unusual/Complicated Anesthesia	□ yes	□ no
Malignant Hyperthermia	□ yes	□ no
Do you have sleep apnea?	□ yes	□ no
Do you use oxygen at home	□ yes	□ no
If yes, do you use oxygen at night?	□ yes	□ no
Do you use a CPAP at night?	□ yes	□ no
History of loud snoring?	□ yes	□ no
History of daytime sleepiness?	□ yes	□ no

22. PAST HOSPITALIZATIONS:

□ NONE

List year and reason (most recent first)

1)
2)
3)
4)

23. PREVIOUS OPERATIONS:

□ NONE

List year, reason, hospital (most recent first)

1)
2)
3)
4)

24. LIST ALL MEDICATIONS YOU ARE NOW TAKING

(include prescription, over the counter, herbal)

□ NONE

Medication	Dosage/Freq
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

25. ALLERGIES:

Have you ever been told you have an allergy?

□ none □ latex □ IV contrast □ shellfish □ eggs

□ others (list allergy and reaction)

_____

_____

_____

_____

26. FAMILY HISTORY:

(list relationship to you)

Heart disease
Stroke
Asthma
Diabetes
High blood pressure
Cancer (specify)
Colon Cancer or Polyps (Specify)
Ulcerative Colitis
Irritable Bowel Syndrome

27. Date and Location Last Colonoscopy _____

28. Have you recently fallen (Fall Risk Assessment)_____

FOR INTERNAL USE ONLY

Reviewed by: _____

Date: _____