Endoscopy Center of Southern California

PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU ON THE DAY OF YOUR TEST.
OUTPATIENT HEALTH HISTORY QUESTIONNAIRE

1. GENERAL INFORMATION:

Name (Last):_____ First: _____

Date of Procedure: _____ Type of Procedure: _____

Age: _____ Sex: _____ Height: _____ Weight: _____lbs

2. ALLERGIES TO MEDICATIONS OR FOODS (INCLUDING TYPE OF REACTIONS):

A. _____
B. _____
C. _____
D._____

3. MEDICATIONS YOU ARE TAKING (PRESCRIPTION & NON-PRESCRIPTION, INCLUDING EYE DROPS):

DRUGS/DOSAGE	**DRUGS/DOSAGE**
A. _____	F. _____
B. _____	G. _____
C. _____	H. _____
D. _____	I. _____
E. _____	J. _____

4. PLEASE INDICATE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING BY PLACING A CHECK IN THE APPROPRIATE BOX:

PATIENT HISTORY	**PAST SURGERY/COMMENTS**
o GLAUCOMA	_____
o HEART DISEASE	_____
o MITRAL VALVE PROLAPSE	_____
o RHEUMATIC HEART DISEASE	_____
o PACEMAKER	_____
o HYPERTENSION	_____
o STROKE	_____
o LUNG DISEASE	_____
o VIRAL HEPATITIS	_____
o KIDNEY DISEASE	_____
o DIABETES	_____
o CANCER	_____
o PARKINSON'S DISORDER	_____
o SEIZURE DISORDER	_____
o GASTROINTESTINAL DISORDERS	_____
o BLEEDING &/OR BLOOD DISORDERS	_____
o BONE DISORDERS	_____
o PROSTHESIS/IMPLANT	_____
o PAIN	_____
o HISTORY OF ANESTHESIA PROBLEMS	_____
o ARTIFICAL HEART VALVE	_____
o PREGNANT/LMP	_____

REVIEWED AND COMPLETED BY: _____