

# Procedure Medical Checklist

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone #: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Procedure Requested: Colonoscopy (colon): \_\_\_\_\_ EGD (stomach): \_\_\_\_\_

Do you have ABDOMINAL pain? Yes No Do you have hemorrhoids? Yes No

Chief Complaint: \_\_\_\_\_

Allergies to medication: \_\_\_\_\_

List of current medications: \_\_\_\_\_

## MEDICAL HISTORY

Yes/No Blood Thinners	Yes/No High Blood Pressure	Yes/No Rectal Bleed
Yes/No History of Heart Failure	Yes/No Kidney Disease	Yes/No Heart Murmur
Yes/No Heart Disease	Yes/No History of Kidney Disease	Yes/No Pacemaker
Yes/No Heart Attack	Yes/No COPD/Emphysema	Yes/No Take Aspirin
Yes/No Diabetes	Yes/No Excessive Bleeding	Yes/No Artificial Joints
Yes/No Take Insulin ?	Yes/No Mitral Valve Prolapse	Yes/No Sleep Apnea
Yes/No Abdominal Pain	Yes/No Hemorrhoids	Yes/No Blood in stool

Last Colonoscopy: \_\_\_\_\_ Last Barium Enema: \_\_\_\_\_

Colon Surgery: \_\_\_\_\_ When: \_\_\_\_\_ Stomach surgery: \_\_\_\_\_ When: \_\_\_\_\_

Please List any serious Illness: \_\_\_\_\_

Please list any surgeries: \_\_\_\_\_

Family history of: Colon cancer \_\_\_\_\_ Stomach cancer \_\_\_\_\_ Polyps \_\_\_\_\_

I affirm that the above is accurate.

Signature \_\_\_\_\_ Date \_\_\_\_\_