Brandywine Valley Endoscopy Center Patient Pre-Procedure Questionnaire/Medical History

Please Print Clearly (To be completed by the patient prior to surgery)

Past Medical Illnesses:

Head & Neck (ENT)

TMJ (jaw) Disease	Y	N
Limited Neck Movement	Y	N
Dentures or Partial Plates	Y	N
Contact Lenses	Y	N
Hearing Aids	Y	N

Heart

History of heart attack	Y	N
Chest Pain (Angina)	Y	N
Irregular Heart Beat	Y	N
Mitral Valve Prolapse	Y	N
Congestive Heart Failure	Y	N
High Blood Pressure	Y	N
Pacemaker/Defibrillator	Y	N

Lungs

Recent cold or Sore Throat	Y	N
Asthma/Wheezing	Y	N
Productive Cough	Y	N
TB or positive PPD Test	Y	N
Pneumonia/COPD/Emphysema	Y	N
C-PAP Machine	Y	N

GI

History of Hepatitis/Liver DX	Y	N
Heartburn/Ulcers/ Reflux	Y	N
Hiatal Hernia	Y	N

GU

History of Kidney Disease/failure	Y	N
Recurrent bladder or prostate	Y	N
Are you pregnant?	Y	N

Date of last menstrual period _______________

Endocrine

History of steroid use # of years ___	Y	N
Diabetes # of years ___	Y	N
Thyroid Disease	Y	N

Neuro

Weakness/Numbness Arms/Legs	Y	N
History of Stroke	Y	N
Seizure Disorder	Y	N
Migraine Headaches	Y	N
Back Pain	Y	N

Blood Disorder

History of Blood Transfusion	Y	N
Bleeding Disorder	Y	N
Anemia	Y	N
HIV Positive	Y	N

Past Surgical History:

List all Past Surgeries_______________________
____
____
____
____

Any problems with anesthesia during above Procedure(s)? Yes ________ No _______

Any family history of anesthesia problems? Y N

List medications with dosages and other Treatments that you are taking (including non-prescription and herbal medicines): __________
____
____
____
____
____
____

Allergies

Allergies to drugs, latex or adhesive tape (list reaction)________________________________
____

Family History

Please list any significant history of heart disease high blood pressure, cancers, diabetes or stroke in immediate family (parents) _______________
____
____
____

Social History

Age: _______ Height: ________ Weight: ____

Cigarettes (packs per day) ______ # of years ___

If you have stopped smoking, how many years ago? _________________

Alcoholic Beverages: None____ Social____ Moderate ____ Heavy ____

Recreational Drug Use: Yes ____ No ____

Family Physician: _________________________

Phone: __________________________________

Cardiologist: _____________________________

Phone: __________________________________

Patient Name: ____________________________