Court Endoscopy Center of Frederick, Inc. CEC)

PATIENT MEDICAL & SURGICAL HISTORY

CEC Name	**Date** _____
SS	**DOB**
Dr.	**Ref. Dr.**

What Procedure are you scheduled to have done? _____
Why does your physician want to perform the procedure _____
Name & Phone number of person taking you home: _____

Please call immediately if you:

➢ ***have a pacemaker/internal defibrillator (please bring your card)***

Do you have Advance Directives, i.e., Living Will, etc., in place now? ☐ **Yes** ☐ **No**

(If you currently have an Advance Directive in place, according to Maryland Law, a copy of this is required for your records at Court Endoscopy Center of Frederick, Inc.. Please bring a copy with you the day of your appointment.)

Please answer Yes or No to the following disorders and give any explanation necessary.

	YES	NO		YES	NO
CARDIAC			**MUSCULO-SKELETAL**		
Hypertension *(High Blood Pressure)*			Arthritis-where		
Coronary Artery Disease			Back Problems		
Angina			Neck Problems		
Heart Attack			Joint replacements		
			Metal Implants-where		
Chest pain with exertion			**GASTO-INTESTINAL**		
Cardiac (Coronary) Bypass Surgery			Family history colon cancer		
Cardiac (Coronary) Angioplasty			Abdominal surgery		
Cardiac (Coronary) Stents			Hemorrhoids		
Congestive Heart Failure			Colitis		
Irregular Heart Beat			GERD (gastro-esophageal reflux)		
Pacemaker			Ostomy		
Defibrillator			Hiatal Hernia		
Heart Murmur			Cirrhosis		
Mitral Valve Prolapse			Polyps		
Heart Valve Replacement			Diverticulosis / Diverticulitis		
Peripheral Vascular Disease			Crohn's		
Endocarditis (Heart Infection)			Liver Disease		
RESPIRATORY			Irritable Bowel Syndrome		
Asthma - Rescue Inhaler			Gastric Ulcer		
Emphysema			Barrett's Syndrome		
TB			Hepatitis *(state type)*		
COPD			**MISCELLANEOUS**		
Smoking (state packs per day)			Bleeding Disorder (state type)		
Sleep Apnea *(Sleep with CPAP)*			Glaucoma		
NEUROLOGICAL			Cancer *(state type and location)*		
Stroke / TIA			Kidney Failure or Insufficiency		
Seizures-last one when			Kidney Stones		

ENDOCRINE			HIV/AIDS		
Diabetes					
Thyroid Problems					

Explanation: _____
_____
_____
_____
_____

Allergies to Medications: _____
_____

Allergy to Latex? **Yes** ☐ **No** ☐

Allergies to contrast? (IVP/CT Dye) **Yes** ☐ **No** ☐

Please list any surgeries that you have had:
_____
_____
_____
_____

Are you pregnant? **Yes** ☐ **No** ☐

Do you have a belly piercing? **Yes** ☐ **No** ☐ **If yes, please remove prior to procedure**.

Height _____ Weight _____

Have you had any problems with intravenous sedation?

☐ Yes ☐ No Describe _____

Check if you use any of the following:

Alcohol ☐ Yes ☐ No Quantity per day _____
Tobacco ☐ Yes ☐ No Quantity per day _____
Narcotics ☐ Yes ☐ No Quantity per day _____

You will be called 24-72 hours post-procedure. If you are unavailable, may we leave a message on your answering machine or with another

☐ Yes ☐ No

If with another party(s) please provide name(s): _____

Medication Reconciliation List attached Yes ☐ No ☐

Medication List reviewed by nurse Yes ☐ No ☐

Patient Signature *Signature of Reviewing RN*

Revised 7/29/10