ROCHESTER GASTROENTEROLOGY ASSOCIATES LLP
PRE-PROCEDURE HEALTH HISTORY

Name: _____ Date of Birth: _____
Primary Care Doctor: _____ OB/GYN Doctor: _____
Weight: _____ Height: _____

A. Allergies: List **medications** you are allergic to and the **reaction** to them:

_____
_____

B. List all medications you are currently taking, dosage and when last taken: (If exceeds the line, mail list with this form to the office.)

Medications	Dosage	# of times	Last taken

C. Medical History: Do you now or have you ever had:

a)	A heart attack	Yes	No	k) Seizure disorder	Yes	No
b)	Congestive Heart Failure	Yes	No	i) Kidney disease	Yes	No
c)	Heart Valve replacement	Yes	No	m) Bleeding problems	Yes	No
d)	Endocarditis /Rheumatic fever	Yes	No	n) Colon Cancer	Yes	No
e)	Chest pain/pressure	Yes	No	o) Diabetes	Yes	No
f)	Irregular heart beat	Yes	No	p) Hepatitis	Yes	No
g)	Pacemaker/Defibrillator	Yes	No	Other medical problems: _____		
h)	Asthma/COPD	Yes	No	_____		
i)	High Blood Pressure	Yes	No			
j)	Family history colon cancer	Yes	No	EVER HAD A GASTROSCOPY	Yes	No
	WHO: _____			EVER HAD A COLONOSCOPY	Yes	No

D. Surgeries: List of all previous surgeries:

_____
_____

E. Do you smoke? Yes No If yes, how many? _____

F. Do you drink alcohol? Yes No If yes, how much? _____

G. Do you use recreational drugs? Yes No If yes, what? _____

H. Do you have any concerns or problems with sedation we should be aware of? Yes No

_____
_____