VALLEY GASTORENTEROLOGY CONSULTANTS
PRE-COLONOSCOPY HISTORY

Demographic and Contact Information

DATE: _____NAME:_____

DATE OF BIRTH: _____GENDER: _____

HOME#:_____WORK#:_____ REFERRING PHYSICIAN: _____

Past Medical History:
Weight: _____ Height: _____

List all chronic medical illness (e.g. Hypertension, diabetes, heart or lung disease) if any: (Attach additional sheets if needed)

1. _____ **5.** _____
2. _____ **6.** _____
3. _____ **7.** _____
4. _____ **8.** _____

List major surgical procedures you had in the past, if any: (Attach additional sheets if needed)

1. _____ **3.** _____
2. _____ **4.** _____

List all medications with dose and frequency, if any: (Attach additional sheets if needed)

Name: _____ **Dose**: _____ **Frequency**: _____

Name: _____ **Dose**: _____ **Frequency**: _____

Name: _____ **Dose**: _____ **Frequency**: _____

Name: _____ **Dose**: _____ **Frequency**: _____

Name: _____ **Dose**: _____ **Frequency**: _____

Name: _____ **Dose**: _____ **Frequency**: _____

Name: _____ **Dose**: _____ **Frequency**: _____

List all drug allergies, if any: _____

Pharmacy Information:

Pharmacy Name: _____

Address: _____ City: _____ State: _____ Zip:_____

Any adverse reaction or complications to anesthesia? Please explain in detail. _____

_____

Do you have any history of Sleep Apnea? _____

Do you smoke? _____ If yes, how make cigarettes a day? ___

Do you drink alcohol any more than a moderate amount twice a week? _____ Please Explain. _____

Any past or current history of illicit drug use? _____ Please Explain. _____

List all family members (1st and 2nd degree relatives) that have been diagnosed with colon or uterine cancer and **age** of diagnosis:

_____

_____

Have you had a colonoscopy in the past? □Yes □No If yes, indicate date and reason for colonoscopy:_____

_____

Name of physician who performed colonoscopy:_____

What were the findings? _____