SEASIDE ENDOSCOPY PAVILION

34444 King Street Row
Lewes, DE 19958
302-644-3852

HEALTH HISTORY

Please complete this form and bring it with you on the day of your procedure

NAME: _____ PROCEDURE: _____

EMAIL ADDRESS: _____

Do you have an **Advance Directive** or **Living Will?** Yes___ No ___
If yes, please bring a copy with you. If no, would you like information? Yes___ No ___

Please check if you have / have had any of the following:

Diabetes		Colon Polyps – personal or family	
Heart Attack		Colon Cancer – personal or family	
Pacemaker		Cancer – Type? _____	
AICD		Thyroid Disease	
Artificial Heart Valves		Kidney Disease	
Cardiac Stents		Liver Disease	
Atrial Fibrillation		Hepatitis	
Bleeding Disorders		HIV / AIDS	
Anemia		Arthritis	
High Blood Pressure		Seizures	
Stroke		Anxiety / Depression	
TIA		Parkinson's	
Dizziness		GERD	
Rheumatic Fever		Hiatal Hernia	
Scarlet Fever		Barrett's Esophagus	
Asthma		Stomach Ulcers	
COPD		Diarrhea	
TB		Constipation	
Recent Cold / Cough		Crohn's	
Sleep Apnea		Ulcerative Colitis	
CPAP Use		Irritable Bowel Syndrome (IBS)	
Broken / Loose Teeth		Weight Loss Surgery/ Medications	
Dentures		Glasses / Contacts	
Have you fallen in the last year?		Hearing Aids	
		Walker, Cane, Assistive Device	
Females: Any possibility you could be pregnant? ____ Are you breastfeeding? _____			
Do you use:			
Tobacco? Current _____ Former _____ Packs per day? _____ Years? _____			
Marijuana? What form/method? _____ Last time? _____			
Recreational Drugs? Type: _____ Last time? _____			
Alcohol? Current _____ Former _____ Frequency/Quantity _____			

Please list any Surgeries:

Procedure	Procedure
Personal or family history of difficulties with anesthesia?	**Yes _____ No _____ If yes, reaction:**

<u>Patients may not drive after receiving sedation / anesthesia.</u>

Please list name and contact number for person taking responsibility for you and driving you home after your procedure:

Name: _____ Cell Number: _____

<u>Please note these important reminders:</u>

- **No Smoking or Tobacco use on day of procedure**
- **No Medicinal or Recreational Marijuana use within 24 hours of procedure**
- **You may not have a taxi, Uber, or bus take you home UNLESS you also have a responsible adult over 18 years riding with you**
- **Contact the office if you are taking weight loss medications or supplements – they might need to be stopped prior to your procedure**

Please list all allergies and sensitivities

Include medications / drugs, materials, food, and environmental items

Attach additional page if necessary

Allergies / Sensitivities	Reaction
☐ No know medication allergies	
Are you allergic / sensitive to Latex? **Yes _____ No _____** **If yes, reaction:**	

Please list all medications

Include vitamins, supplements, weight loss pills, and other over the counter remedies

Attach additional page if necessary

Medication	Dose	Frequency	Date Last Taken	Reason for Taking	Restart (Nurse's Use Only)

Patient Signature: _____ Date: _____

Nurse Signature: _____ Date: _____