

GASTROENTEROLOGY ASSOCIATES of ROCHESTER, LLP
2440 Ridgeway Avenue, Suite 100 Rochester, NY 14626

Complete this form and bring it with you. Do not mail.

Name _____ Date of Birth _____ Primary Care Physician _____

Do you have a ride home? Yes No Do you have someone spending 12 hours with you? Yes No

Responsible Party (Driver): _____ Phone Number: _____

Phone number where you can be reached after your procedure: Day _____ Evening _____

Have you ever had a Flexible Sigmoidoscopy/Colonoscopy or Gastroscopy in the past? _____

Current complaints/symptoms: _____

Hospitalizations/Surgeries (what & when) _____

Family history of colon cancer, polyps, or any GI related issues: _____

Weight: _____ OB/GYN Physician if applicable: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

- Diabetes (If you check your blood sugar regularly, please check on day of appointment) BG result _____
- A pacemaker/defibrillator** Lung Disease Dialysis Shunt Organ Transplant
- History of Cancer Liver Disease Artificial heart valve Immune Problem
- Hepatitis Heart valve problem Anxiety Depression
- Kidney disease Seizure disorder High cholesterol High Blood Pressure
- Heart disease _____ Stroke Thyroid Problems Arthritis
- Asthma Bleeding tendencies Other _____

**If you have a pacemaker/defibrillator, please bring the identification card with you. Please let your Doctor know if you have a pacemaker or defibrillator prior to your appointment day.

Do you have any history of problems with anesthesia/sedation? Yes No If yes, what were the problems? _____

Smoking and Substance/Alcohol History

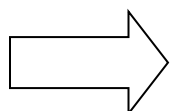
Do you regularly use tobacco products? Yes – How much? _____ No Quit – when? _____

Do you use recreational drugs? Yes No If yes – What? _____ Date last used? _____

Do you drink alcoholic beverages? Yes No If yes – What? _____ How much? _____

Date of last drink _____

OVER



ENDOSCOPIC PROCEDURES

MEDICATION/ALLERGY LIST/RECONCILIATION FORM

MEDICATION LIST

- Medications **must** be listed on this form, not on a separate piece of paper to be attached.
- In order to serve you most efficiently, please list all of your **current medications**, including any **over the counter medications, vitamins, or herbal supplements** that you are taking. This includes any medications, such as **aspirin or anticoagulants**, that you have stopped for this procedure.

MEDICATION/DOSAGE

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Do you take any medications for pulmonary hypertension or erectile dysfunction (Viagra, Cialis)? _____ Last dose: _____

ALLERGY FLAG

NO KNOWN ALLERGIES

Are you allergic or sensitive to any medications? (Example, has any medication ever caused respiratory issues or skin rashes) Yes No If yes, name of medication and reaction: _____

Are you allergic to Latex (Rubber) Yes No If yes, type of reaction: _____

Are you allergic to any foods? Yes No If yes, please list food and reaction: _____

I have been advised that all jewelry, piercings, and removable non-medical devices should have been left at home or removed prior to the procedure.

Pre-Procedure Reconciling Nurse Signature: _____ **Time:** _____

Pre-Procedure Reconciling MD Signature: _____ **Time:** _____

Reconciliation Date: _____ **Patient Signature:** _____