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 <u>must</u> 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	MEDICATION/DOSAGE

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:_____