

We Moved our Endo Area Your Procedure will now be done at our new Endoscopy Center

Burlington County Endoscopy Center-Pre Endoscopy Medical History Update Form

Name _____ Date of Birth (Month\Day\Year) ____ \ ____ \ ____

Your answers on this form will help your Doctor understand your medical history. If you are uncomfortable with any question, do not answer it. Best estimates are fine.

My Procedure to be done is- _____ The Procedure is being done because of _____

*If you have a fever, cold, or bad cough with phelm in the days before the procedure or if you use Oxygen all the time call our office (609-265-1700) as **your procedure may need to rescheduled***

Please check the boxes below if they apply to You in any of the History Sections:

Your Own Past Gastrointestinal (GI) History:

- | | |
|--|---|
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Heartburn or Reflux |
| <input type="checkbox"/> Hepatitis __A or __B or __C | <input type="checkbox"/> Other Liver Disease |
| <input type="checkbox"/> Gastroparesis | <input type="checkbox"/> Ulcer Disease what type? _____ |
| <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Barrett's Esophagus | |

List other GI History:

Your Own Past Medical History:

- | | |
|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Atrial Fibrillation |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> History of stroke |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma or breathing disorder |
| <input type="checkbox"/> Angioplasty when? _____ | <input type="checkbox"/> Kidney Disease (____ check if on dialysis) |
| <input type="checkbox"/> Joint Disease or Arthritis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Colon <input type="checkbox"/> Breast <input type="checkbox"/> Prostate <input type="checkbox"/> Other |
| <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Are you using CPAP | |

List all additional important History or symptoms:

Your Own Past Procedure History:

- Previous Upper Endoscopy-When _____
- Previous Colonoscopy-When _____ Any Polyps? ____yes or ____no
- Requires Antibiotics for procedures ____yes or ____no

Your Past Anesthesia History:

- | | |
|--|---|
| <input type="checkbox"/> No Problems in the past | <input type="checkbox"/> Use Home Oxygen |
| <input type="checkbox"/> Allergy to eggs\sulfites\soybeans (circle if apply) | <input type="checkbox"/> Dentures _____ : |
| <input type="checkbox"/> Bleeding after surgery or dental work | <input type="checkbox"/> Family History of Malignant Hyperthermia |
| <input type="checkbox"/> Family History of Anesthesia problems | <input type="checkbox"/> Weight in pounds _____ |
| <input type="checkbox"/> Height in inches _____ | |

List any additional Anesthesia details or problems with Anesthesia below:
