ATLANTA ENDOSCOPY CENTER Ltd.
PRE-OP MEDICAL HISTORY REVIEW

Name:______________________________MR#______________________________DATE___________________

List all medications and doses (Prescriptions Dietary Supplements and over the Counter) taken daily & reason for taking:

Medicine & dose	Reason	Medicine & dose	Reason

Do you take an anticoagulant?	Date last taken?

DRUG ALLERGIES:

LIST ANY SURGERIES & HOSPITALIZATIONS (YEAR).

Surgery	Year	Medical Hospitalizations	Year

Answer yes if you EVER have been treated for any of these conditions.

CONDITION	YES	NO	FAMILY HISTORY	YES	NO
Hypertension (High blood pressure)			Hepatitis Jaundice		
Diabetes			Colon Polyps		
Heart Disease			Colon Cancer		
Hepatitis/ Jaundice			Other Cancer		
Colon Polyps/Cancer					
Lung Disease or Cough					
Stomach Ulcers					
Difficulty Swallowing					
Blood in Stool					
Glaucoma					
Heartburn					
Seizures					
AIDS/HIV					
Are you Pregnant?					
Implant or hip prosthesis					
Bleeding disorders, such Clotting problems?					
Any other medical problems					

Patient Signature____Date____

RN Review____Date____

MD Review____Date____

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