Print Form

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ECNB
Endoscopy Center of North Baltimore

PATIENT MEDICAL & SURGICAL HISTORY

PLEASE FILL OUT PRIOR TO ARRIVAL

Name

SS# DOB

What procedure are you scheduled to have done? Dr. Ref. Dr.

Reason physician recommended procedure Email

Name of person taking you home

Phone Number of person taking you home

PLEASE CALL IMMEDIATELY IF YOU HAVE THE FOLLOWING:

- ***have an ARTIFICIAL HEART VALVE, or JOINT REPLACEMENT ,TRANSPLANT OF ANY ORGAN***
- ***have a PACEMAKER or INTERNAL DEFIBRILLATOR, CARDIAC STENTS***
- ***taking BLOOD THINNERS (i.e. COUMADIN, PLAVIX, PLETAL etc.)***
- ***are on HOME OXYGEN or DIALYSIS, or have an active INFECTION (C-Diff, MRSA)***

(If you currently have an Advance Directive in place, according to Maryland Law, a copy of this is required for your records at Endoscopy Center of North Baltimore. Please bring a copy with you the day of your appointment.) Do you have Advance Directive, i.e. Living Will, etc. in place now ? ☐ Yes ☐ No

Please answer Yes or No to the following disorders and give any explanation necessary .

Disorder		Disorder	
High Blood Pressure	☐ Yes ☐ No	Internal Defibrillator/ Pacemaker	☐ Yes ☐ No
Heart Attack/Angina	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Congestive Heart Failure	☐ Yes ☐ No	Lung Disease/ Tuberculosis/Other	☐ Yes ☐ No
Heart Murmur/Mitral Valve Prolapse	☐ Yes ☐ No	Sleep Apnea/CPAP/ Home Oxygen	☐ Yes ☐ No
Valve Replacement/ Endocarditis	☐ Yes ☐ No	Asthma/Emphysema/ COPD	☐ Yes ☐ No
Cardiac Surgery/Stents	☐ Yes ☐ No	Liver Disease/Hepatitis/ Other	☐ Yes ☐ No
Irregular Heartbeat	☐ Yes ☐ No	Infectious Disease/Other	☐ Yes ☐ No
Kidney Disease/Renal Failure	☐ Yes ☐ No	Breast Cancer	☐ Yes ☐ No
Bladder Problems	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Thyroid Problems	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No

Disorder		
Back/Neck Problems	☐ Yes	☐ No
Any Joint Replacements	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Seizures/Epilepsy	☐ Yes	☐ No
Bleeding Disorders/ Anemia	☐ Yes	☐ No
Stomach Ulcer	☐ Yes	☐ No
Reflux/Esophagitis	☐ Yes	☐ No
Esophageal Stricture	☐ Yes	☐ No
Barretts Esophagus	☐ Yes	☐ No
Hiatal Hernia	☐ Yes	☐ No

Disorder		
Family History of Colon Cancer	☐ Yes	☐ No
Bowel Surgery/Colon Cancer	☐ Yes	☐ No
Polyps/Colon Polyps	☐ Yes	☐ No
Hemmorrhoids	☐ Yes	☐ No
Ostomy	☐ Yes	☐ No
Diverticulosis/ Diverticulitis	☐ Yes	☐ No
Crohn's Disease/ Ulcerative Colitis	☐ Yes	☐ No
Irritable Bowel/ Spastic Colon	☐ Yes	☐ No
Diarrhea/C-Diff	☐ Yes	☐ No
Other	☐ Yes	☐ No

History/Condition		
Any past major surgeries? (Please list below)	☐ Yes	☐ No
Other medications?	☐ Yes	☐ No
Female Only: Are you pregnant?	☐ Yes	☐ No

History/Condition		
Allergies to medication? (Please list below)	☐ Yes	☐ No
Allergies to latex?	☐ Yes	☐ No
Allergies to contrast?(IVP Dye)	☐ Yes	☐ No

Explanation of Above:

PLEASE LIST ALL YOUR CURRENT MEDICATIONS. INCLUDE ALL OVER THE COUNTER MEDICATIONS (VITAMINS/ HERBAL) taken on a regular basis. Include if you take ASPIRIN or IBUPROFEN of any kind.

Name of Medicine	Dose and Route	Frequency	Last Dose	Resume after procedure? Y/N	List New Medications added after procedure
					1.
					2.
					3.
					Copy of Medical List given to patient:

Height ☐ Have you had any problems with Anesthesia or Intravenous sedation? ☐ Yes ☐ No

Weight ☐ Describe ☐

On a scale of 0-10 (with 0 being no pain and 10 being very severe) how would you define your level of pain?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Check if you use any of the following:

Alcohol ☐ Yes ☐ No Quantity per day ☐

Tobacco ☐ Yes ☐ No Quantity per day ☐

Narcotics ☐ Yes ☐ No Quantity per day ☐

You will be called 24-72 hours post-procedure. If you are unavailable, may we leave a message on your answering machine or with another party at that number? ☐ Yes ☐ No

If with another party(s) please provide name(s): ☐

Disclaimer

By printing and/or signing this form you acknowledge that Endoscopy Center of North Baltimore has allowed you full access to all forms of disclosure required by Maryland state law and by any and all organizations requiring various types of disclosure to include, but not restricted to, a patient's bill of rights, our policy on Advanced Directives, a statement of disclosure of ownership by our doctors, a list of credentials for each of our doctors, etc. A full list of our current forms of disclosure can be found at http://www.ecnb.org/disclosure.html. Each doctor's individual credentials can be found at the "Credentials" link next to their name at http://www.ecnb.org.

Signature of Patient	**Signature of Reviewing RN**	**Date**