Patient Name: _____

BRYN MAWR MEDICAL SPECIALISTS
ENDOSCOPY CENTER

NEXT BUSINESS DAY

HISTORY & PHYSICAL ***FOLLOW- UP PHONE CALL #:*** _____

Please complete the following information. This information will assist the physicians at Bryn Mawr Medical Specialists Endoscopy Center in making decisions regarding your care while a patient at the Center. Rev.10/2016

*** DATE OF LAST COLON:** _____	**HEALTH HISTORY** ❑ **B/P & IV LIMITATIONS L R ARM**
Anesthesia History	❑ Nausea/Vomiting ❑ Difficulty Awakening ❑ Family History of Anesthetic Complications ❑ Malignant Hyperthermia ❑Other _____ ❑ **None**
Airway & Teeth	❑ Caps/Crowns ❑ Bridges / False Teeth ❑ Loose Teeth ❑ Braces / Retainers ❑ Snoring ❑ Difficulty swallowing ❑ Trouble Opening Mouth ❑ Mouth, Tongue or Body Piercing ❑ **None**
Tobacco	❑ Smoke_____ Packs/Day For _____ Years ❑ Quit _____ yr(s) ago ❑ **None**
Alcohol/Drugs	❑ Daily ❑ Weekly ❑ Other _____ ❑ Recreational Drugs_____ ❑ **None**
Gyn/ Pregnancy	Is there any chance you could be pregnant? ❑ Yes ❑ No Comments: _____ Do you menstruate? ❑ Yes ❑ No If so, when was your last menstrual period? _____
Heart	❑ Heart Attack ❑ Angina ❑ Mitral Valve Prolapse ❑ CHF ❑ Valve Problems ❑ Aortic Stenosis ❑ High Blood Pressure ❑ Low Blood Pressure ❑ Pacemaker / Defibrillator ❑ Heart Disease ❑ Cardiac Stents ❑ Irregular Heartbeat (*describe*): _____ Other _____ ❑ **None**
Lungs	❑ Asthma ❑ Shortness of Breath ❑ Wheezing ❑Emphysema / COPD ❑ Pneumonia ❑ TB ❑ Chest cold in last 6 Weeks ❑ Cough ❑ Sleep Apnea CPAP? ❑ *Yes* ❑ *No* ❑ Other ❑ **None**
Kidneys/Bladder	❑ Stones ❑ Infection ❑ Renal Failure ❑ Dialysis ❑ BPH ❑ Difficulty urinating ❑ **None**
Neurological	❑ Stroke ❑ Migraines ❑ Seizures ❑ Dizziness ❑ Fainting ❑ Paralysis ❑ Memory Changes ❑ **None**
Diabetes	❑ Insulin ❑ Pills ❑ Diet controlled ❑ Hypoglycemia ❑ **None**
Circulation	❑ Phlebitis ❑ Clots ❑ Bleeding Disorder ❑ Other _____ ❑ **None**
Thyroid	❑ Under Active ❑ Over Active ❑ Thyroid Surgery ❑ Other _____ ❑ **None**
Muscles & Joints	❑ Muscle Disease ❑ Osteoarthritis ❑ Rheumatoid Arthritis ❑ Back Problems ❑ Neck Problems ❑ Scoliosis ❑ Artificial Joints ❑ Osteoporosis ❑Other _____ ❑ **None**
Digestive	❑ Hiatal Hernia ❑ Ulcer ❑ Reflux ❑ Barrett's Esophagus ❑ Esophageal Stricture ❑ Diverticulosis ❑ History of Polyp ❑ Rectal bleeding ❑ Crohns / Colitis ❑ Constipation ❑ Diarrhea ❑ Pain _____ ❑ IBS ❑ Family History of Colon Cancer ❑Screening ❑_____ ❑ None
Liver	❑ Yellow Jaundice ❑ Hepatitis ❑ Cirrhosis ❑ Mono (Active) ❑ Other _____ ❑ **None**
Psycho/Social	❑ Anxiety ❑ Panic Attacks ❑ Depression ❑ Bipolar ❑ Physical/Psychological abuse ❑ **None**
Other	❑ Glaucoma ❑ Anemia ❑ History of blood transfusions ❑ Infected with MRSA or MDRO ❑ Rheumatic Fever ❑ High Cholesterol ❑ Bruises Easily ❑ Cancer _____ ❑ Hearing Impairment ❑ Unsteady Gait ❑ History of Falls ❑ _____ ❑ None

ALLERGIES (Drugs, Latex, Dyes, Food, Tape) ❑ **None**	**Reaction**	**OPERATIONS (LIST ALL)** ❑ **None**

PRESCRIPTION MEDICATIONS (INCLUDE DOSE/FREQUENCY) ❑ **NONE** ❑ **DOSAGE UNKNOWN BY PT.**		**OTHER MEDICATIONS** ❑ **None** **(Including aspirin products, vitamins)** **Pt denies ASA, Ibuprofen, Aleve** ❑

I attest the information I have provided is true to the best of my knowledge.

Patient Signature: _____ **Date :** _____

Reviewed & Verified by RN : _____ **Date :** _____