

Patient Name: \_\_\_\_\_

**BRYN MAWR MEDICAL SPECIALISTS  
ENDOSCOPY CENTER**

**NEXT BUSINESS DAY  
FOLLOW- UP PHONE CALL #: \_\_\_\_\_**

**HISTORY & PHYSICAL**

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.6/2019

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

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

**Patient Signature:** \_\_\_\_\_ **Date :** \_\_\_\_\_  
**Reviewed & Verified by RN :** \_\_\_\_\_ **Date :** \_\_\_\_\_  
**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_