Denver West Endoscopy Center

Patient Health History & Medication Reconciliation Form

Patient Name: ____ Date of Birth: _____ /_____ /_____

Primary Doctor: ____

Referring Doctor (if not your primary doctor): ____

Primary Care Provider Office Phone #: ____

Reason for procedure: ____

Health History

Prior Colonoscopy: Date: _____ /_____ /_____ Findings: ____

Heart Disease/Disorders:
- ☐ High Blood Pressure
- ☐ History of MI (heart attack)
- ☐ Arrhythmia: ______________________
- ☐ Leaky/Prolapsed Valves
- ☐ Other______________________

Lung Disease/Disorders:
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Oxygen use at home: (when & liters used) ______________________
- ☐ Other: ______________________

Gastrointestinal Disease/Disorders:
- ☐ Colonic Polyps
- ☐ Personal History of Intestinal Cancer
- ☐ Ulcerative Colitis
- ☐ Barrett's Esophagus
- ☐ Dysphagia (Difficulty Swallowing)
- ☐ GERD
- ☐ Other: ______________________

Family History of Colon Cancer or Colon Polyps:
- ☐ Colon Cancer (Relation & Age at Diagnosis) ______________________
- ☐ Colon Polyps (Relation & Age at Diagnosis) ______________________

Implanted Medical Devices:
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Plates/Pins/Screws/Rods
- ☐ Artificial Joint(s): ______________________ ______________________

Diabetes: (Treatment)
- ☐ Insulin
- ☐ Oral Medication
- ☐ Diet
- ☐ Most recent blood glucose & date/time ______________________

Bleeding or Clotting Disorders: ______________________

Infectious Disease:
- ☐ HIV
- ☐ Hepatitis (B or C)
- ☐ Tuberculosis
- ☐ Other: ______________________

Pregnancy Status: (if applicable)
- ☐ Pregnant
- ☐ Hysterectomy
- ☐ Post Menopause
- ☐ Denies Pregnancy (LMP): ______________________

Surgical History:
- ☐ Hysterectomy
- ☐ Appendectomy
- ☐ Cholecystectomy
- ☐ Other: ______________________ ______________________

Social History:
- ☐ Alcohol
- ☐ Tobacco
- ☐ Recreational Drugs/Medical Marijuana: ______________________ ______________________

Other Health History: ____
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