



Gastrointestinal History

Patient Name: _____ Patient Date of Birth: _____

Current height: _____ Current Weight: _____

Do you have a history of colon cancer, rectal cancer or colon polyps?

☐ Yes ☐ No

Do you have a family history of any other gastrointestinal cancers?

☐ Yes ☐ No ☐ Family history unknown

Do you have a family history of Crohn's disease or ulcerative colitis?

☐ Yes ☐ No ☐ Family history unknown

Do you have a family history of liver disease?

☐ Yes ☐ No ☐ Family history unknown

Additional personal Medical history: Please check all that apply:

- ☐ pacemaker ☐ defibrillator ☐ heart stent(s)
- ☐ atrial fibrillation ☐ history of heart attack ☐ stroke
- ☐ sleep apnea ☐ HIV/AIDS ☐ tuberculosis
- ☐ med port ☐ home oxygen use ☐ use of iron supplement
- ☐ none

Are you on blood thinning medication such as Coumadin (Warfarin), Plavix (Clopidpgrel), Effient (Prasugrel), Pradaxa (Dabigatran), Xarelto (Rivaroxaben), Eliquis (Apixaban) or Brilinta (Ticagrelor)?

☐ Yes ☐ No

Are you diabetic?

☐ Yes ☐ No

Have you had any bad reactions to anesthesia or drugs used for sedation?

☐ Yes ☐ No

Do you have allergies to the following:

Eggs ☐ Yes ☐ No

Nuts ☐ Yes ☐ No

Soy ☐ Yes ☐ No

Have you ever had any problems with anesthesia other than nausea, vomiting, difficulty waking, and/or difficulty being sedated?

☐ Yes ☐ No

Have you ever been in cardiac rehab because of a heart attack or a stroke?

☐ Yes ☐ No

Do you have obstructive sleep apnea?

☐ Yes ☐ No ☐ Family history unknown

Please indicate who we may speak with should we need to contact you regarding your healthcare:

☐ No one ☐ Spouse ☐ Significant other ☐ Caregiver ☐ Parent
☐ Sibling ☐ Child ☐ Other

Please give full name of the person we may contact. Please include Area code and phone number. If no one, please state 'none'.

Name: _____ Phone: _____

Is it OK for Huron Gastro to leave a message on your answering machine or voicemail?

☐ Yes ☐ No

Have you had an pneumonia vaccine?

☐ Yes ☐ No

Have you had a flu vaccine?

☐ Yes ☐ No