

ENDOSCOPY PATIENT HISTORY FORM

(Please Print)

NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____

PAST MEDICAL HISTORY: (mark box if you have any of the following)

- High Blood Pressure Kidney Disease
- Diabetes Lung Disease
- Heart Disease Bleeding Disorder or taking Blood Thinner Medication

PAST SURGICAL HISTORY:

Type of operation

Year

_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES: _____

MEDICATIONS: (include dose, how often you take it, and over-the-counter medicines) _____

FAMILY HISTORY OF COLON CANCER and/or COLON POLYPS: **No or None Known**

Relation to you

Approximate age of diagnosis

_____	_____
_____	_____
_____	_____
_____	_____

Date

Patient Signature

Referring Provider:

Date

MD Initials

Primary Care Provider:

Gastroenterology Associates

500 Lilly Road N.E., Suite 204
Olympia, WA 98506

Endoscopy Center, Suite 150
ENDOSCOPY PATIENT HISTORY FORM

11-07

**Patient
Identification**