



# 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 Number: \_\_\_\_\_  
 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: \_\_\_\_\_

### Diabetes: (Treatment)

- Insulin
- Oral Medication
- Diet
- Most recent blood glucose & date/time: \_\_\_\_\_

### Lung Disease/Disorders:

- Asthma
- COPD
- Sleep Apnea
- Oxygen use at home: (When & Liters used)  
\_\_\_\_\_
- Other: \_\_\_\_\_

### Bleeding or clotting disorders:

\_\_\_\_\_

### Infectious Disease:

- HIV
- Hepatitis (B or C): \_\_\_\_\_
- Tuberculosis
- Other: \_\_\_\_\_

### Gastrointestinal Disease/Disorders:

- Colonic Polyps
- Personal history of intestinal cancer
- Ulcerative Colitis
- Crohn's Colitis
- Barrett's Esophagus
- Dysphagia (Difficulty swallowing)
- GERD
- Other: \_\_\_\_\_

### Pregnancy Status: (If applicable)

- Pregnant
- Hysterectomy
- Post Menopause
- Denies Pregnancy (LMP): \_\_\_\_\_

### Other Health History:

\_\_\_\_\_  
 \_\_\_\_\_

### Family history of colon cancer or colon polyps:

- Colon Cancer (Relation & Age at Diagnosis)  
\_\_\_\_\_
- Colon Polyps (Relation & Age at Diagnosis)  
\_\_\_\_\_

### Surgical History:

- Hysterectomy
  - Appendectomy
  - Cholecystectomy
  - Other: \_\_\_\_\_
- \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Implanted Medical Devices:

- Pacemaker
  - Defibrillator
  - Plates/Pins/Screws/Rods
  - Artificial Joint(s): \_\_\_\_\_
- \_\_\_\_\_

### Social History:

- Alcohol:
  - Tobacco:
  - Recreation Drugs/Medical Marijuana:
- \_\_\_\_\_