GRANITE PEAKS ENDOSCOPY

GRANITE PEAKS GASTROENTEROLOGY

PATIENT HEALTH HISTORY

Patient name: _____ **Preferred name:** _____
Date of birth: _____ **Age:**_____ **Gender:** _____ **Height:**_____ **Weight:**_____
Reason for Appointment:_____ **Appointment Date:** _____
Primary Physician:_____ **Referring Physician:**_____
Pharmacy name and location: _____

This questionnaire will become a confidential part of your medical record. If you do not want to answer a question, discuss it privately with your doctor.

ALLERGIES - PLEASE LIST ALL

ALLERGIES: ☐ None ☐ Latex ☐ Iodine ☐ Foods _____

☐ Medication Allergies _____

_____

PATIENT SURGICAL HISTORY (please list all surgeries with approximate date)

_____

_____

_____

_____

_____

Check if you have had a bad reaction to anesthesia: ☐ No ☐ Yes *Explain* _____
Has a blood relative had a bad reaction to anesthesia: ☐ No ☐ Yes *Explain* _____

PATIENT MEDICAL HISTORY (please check Yes or No on all conditions)

Y	N	
☐	☐	Diabetes *(Controlled by: diet, oral medication, insulin)*
☐	☐	Hypoglycemia (Low Blood Sugar)
☐	☐	Thyroid problems/disease
☐	☐	Heart Problems *(Rheumatic Fever, Pacemaker, Murmur, Angina, Heart Attack, Valve Replacement, Irregular Heartbeat, Ankle Swelling)*
☐	☐	Blood clots / Transfusion Problems / Bleeding tendency
☐	☐	High Blood Pressure / Hypertension
☐	☐	Stroke
☐	☐	Seizure
☐	☐	Neurological Problems *(Numbness, tingling, neuropathy)*
☐	☐	Headache/Migraine
☐	☐	Lung Problems *(Asthma, Emphysema, COPD, pneumonia, oxygen use)*
☐	☐	Tuberculosis / TB
☐	☐	Sleep apnea *(snoring, interrupted breathing, CPAP, BIPAP, oxygen use)*
☐	☐	Hepatitis / Liver disease
☐	☐	Kidney / Prostate / Bladder Problems
☐	☐	Stomach Problems *(ulcer, reflux, celiac, Barrett's, nausea, vomiting, choking)*
☐	☐	Bowel Problems *(diarrhea, constipation, hemorrhoids)*
☐	☐	Back Trouble *(Disc problems, numbness, tingling of hands/feet)*
☐	☐	Difficulty Opening Mouth *(TMJ)*
☐	☐	Arthritis
☐	☐	Muscle Disorders *(M.S., Fibromyalgia, Scleroderma, etc.)*
☐	☐	Cancer - Type:_____
☐	☐	Mental Health/Phobias – *(Anxiety, Depression, Bipolar)*
☐	☐	Mental Disability *(Confusion, Memory Loss, Cognitive disability, etc.)*
☐	☐	Skin Problems (czema, Fragile, etc)
☐	☐	Other Medical Problems/Comments:
☐	☐	Any illness, Cold, Cough, Fever within 7 days? If Yes, What?

Y	N	
☐	☐	**Do You Have Any of the Following:** ☐ Living Will ☐ Durable Power of Attorney ☐ Organ Donor Card ☐ Medical Treatment Plan Location of Document(s) _____ ***Granite Peaks GI, LLC does not honor these documents.***
☐	☐	Do You Have a History of Tobacco / Vape Use? Type: _____ Amount: _____/_____Day Quit: _____
☐	☐	Do You Drink Alcoholic Beverages? Type: _____ Frequency: _____/Week Quit: _____
☐	☐	Do You Have a History of Substance Abuse/Addiction? Type: _____ Frequency: _____/Week Quit: _____
☐	☐	Do You Have Any of the Following? ☐ False Teeth ☐ Bridges ☐ Braces ☐ Retainers ☐ Loose Teeth ☐ Capped Teeth
☐	☐	Do You Have Any Physical Limitations, Concerns, or Fears regarding this procedure? ☐ Vision ☐ Hearing ☐ Speech ☐ Language ☐ Learning Needs ☐ Physical Limitations ☐ Environmental Concerns *(room temperature, lighting, etc.)* ☐ Other _____
☐	☐	Women: Is There a Possibility You are Pregnant? Last Menstrual Period: _____

*Driver information for **ENDOSCOPY CENTER PATIENTS ONLY**.*
Driver must remain in the facility for the duration of the procedure.

Driver Name: _____

Relationship:_____

Telephone: _____

Please turn the page for additional information

Patient name: _____ **Date of birth:** _____

SOCIAL HISTORY

Do you have any children? ☐ No ☐ Yes
Do you have any tattoo(s)? ☐ No ☐ Yes
Have you ever received a blood transfusion? ☐ No ☐ Yes
Do you consume caffeine? ☐ No ☐ Yes

What is your occupation?_____

RECENT SCREENINGS (please list approximate date)

If applicable, what year was your last colonoscopy? _____ Where? _____
If applicable, what year was your last mammogram? _____
If applicable, what year was your last bone density scan? _____
If applicable, what year was your last pneumonia vaccine? _____
When was your last flu vaccine? _____

FAMILY HISTORY

Please list any ***family members*** diagnosed with the following conditions and at what age:

Father: Living? Y / N *Cause of death*_____ **Mother**: Living? Y / N *Cause of death*_____ ☐ Adopted

☐ Colon polyps_____ ☐ Cancer (colon)_____

☐ Ulcerative Colitis/Crohn's_____ ☐ Cancer (other)_____

CURRENT MEDICAL SYMPTOMS/CONDITION (please check YES for any additional symptoms you are currently experiencing)

Constitutional:

- ☐ Weight Gain
- ☐ Fevers
- ☐ Night sweats
- ☐ Weight Loss
- ☐ Fatigue

Head and Neck:

- ☐ Hearing deficit
- ☐ Double vision
- ☐ Vision loss

Respiratory/Lungs:

- ☐ Difficulty breathing
- ☐ Frequent cough

Cardiovascular:

- ☐ Chest pain
- ☐ Palpitations

Gastrointestinal:

- ☐ Abdominal pain
- ☐ Blood in the stools
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Vomiting blood
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ Loss of appetite
- ☐ Mucus in stool
- ☐ Nausea
- ☐ Reflux
- ☐ Vomiting

Kidney/Bladder:

- ☐ Blood in urine
- ☐ Urinary frequency

Metabolic/Endocrine:

- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Heat intolerance

Neurological:

- ☐ Dizziness
- ☐ Headache
- ☐ Numbness
- ☐ Tremors
- ☐ Vertigo

Psychiatric:

- ☐ Anxiety
- ☐ Depression
- ☐ Increased stress

Skin/Hair:

☐ Hives ☐ Itching skin ☐ Rash

Musculoskeletal:

- ☐ Back pain
- ☐ Joint pain

Hematologic:

- ☐ Anemia
- ☐ Easy bleeding
- ☐ Easy bruising

Immunologic:

- ☐ Asthma
- ☐ Food allergies
- ☐ Immunosuppression
- ☐ Seasonal allergies

Other conditions not specified:_____

_____

_____

Date	Patient or Legal Guardian Signature	Physician's Signature	Date Reviewed