785-500 REV. 5/04)

NORTH FLORIDA ENDOSCOPY CENTER

SUBJECTIVE HISTORY QUESTIONNAIRE

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING?

PROBLEMS	Yes	No	PROBLEMS	Yes	No
Head or neck injury with loss of Consciousness?			Polio, meningitis or paralysis?		
Broken facial bones?			Seizures or epilepsy?		
Shortness of breath, lung problems, pneumonia, TB, bronchitis or emphysema?			Do you take any MAO inhibitors		
			Do you have kidney disease?		
Cold, sores throat or fever last 2 weeks?			Back pain, injury, or slipped disc?		
Do you smoke? How much?			Fractures? Where?		
Chest x-ray in last 6 months?			Migraine headaches?		
Cancer?			History of blood clots?		
Bowel or stomach problems?			Stroke?		
Diabetes/low blood sugar?			Recent weight loss?		
How much aspirin do you take? _______Tablets a day			Vision problems? Glaucoma?		
Any bleeding problems, you or your family?			Hearing problems?		
Anemia or sickle cell?			Bridgework, dentures, or loose teeth?		
Any blood transfusion?			Other illnesses?		
Muscle weakness, leg cramps, numbness or tingling?			History of drug abuse?		
			Do you have Sleep APNEA ____ apnea machine?		
Rheumatic fever/heart murmur?			Do you drink alcoholic beverages? ___ Drink (s) ___a day, ___ a week ___, a month		
Chest pains, Chest pressure, or angina?			Recent memory loss?		
High or low blood pressure?			Swollen glands?		
Heart attacks?			Night sweats?		
Palpitations, irregular or fast heart beat?			Arthritis/gout?		
Gallbladder trouble?			Unusual reaction to anesthesia, you or family?		
Jaundice, hepatitis or liver trouble?			Female patients only: Are you pregnant?		
Thyroid problems?			Last menstrual period?		

List All Allergies/Sensitivities TO MEDICINES AND/OR PLASTIC/TAPE
____
____

List all Medications taken in the past month _________________________
____
____

LIST ALL PREVIOUS SURGERIES:

Gallbladder **Open heart/bypass Surgery**
Gastric bypass **Colectomy/Colon surgery**
Hysterectomy **Prostate** **Tonsils** **Appendix**
Other Surgeries:______________________________
____

HAVE YOU FALLEN IN THE PAST 60 DAYS NO ____ YES _____ EXPLAIN:____

PLEASE STATE YOUR PRESENT OR RETIRED OCCUPATION____

PLEASE STATE CURRENT PROBLEM:____

PLEASE LIST YOUR PRIMARY and or REFERRING DR.:____

For Upper Endoscopy procedures only. Please remove contact lenses and partial dentures before you come to the procedure room. Crown, carious or loose teeth, and dental appliances may be damaged if you bite down on the plastic airways or mouth- piece that maybe placed in your mouth during your procedure. We cannot be held responsible for this type of damage. Please ask your doctor regarding full dentures.

_________________________________ _________________________________ **Date:____/____/___ Time: ___:____**
Signature of patient or patient's guardian **Signature of witness if patient is unable to sign**

Please Note: ***Your doctor's professional services are not included in your Endoscopy Center bill.***
The doctor's fees are based on the procedure that is done. Your doctor will bill you separately for professional services.

Patient should not write below this line.

☐ **SUBJECTIVE HISTORY REVIEWED. PATIENT NPO AS NOTED.**

☐ **MEETS DISCHARGE CRITERIA** ____/____/_____ ____:____ _________________________**M.D.**
Date Time Physician's Signature

PATIENT LABEL