HealthPartners

Health History Form

Please review and fill out this form. Bring the completed form to your appointment.

Name: _____ Date of Birth:_____

1. What procedure(s) are you having?
   - ◯ Colonoscopy
   - ◯ Upper Endoscopy (EGD)
   - ◯ Flexible Sigmoidoscopy
   - ◯ Other: _____
   - ◯ BRAVO with EGD Placement

2. Why are you having the procedure(s) checked above?
   - ◯ I am having a preventive screening
   - ◯ I have had the following symptoms (for any procedure): _____
     _____

3. If you took a prep, what kind?
   - ○ Miralax + Gatorade or Powerade (Polyethylene glycol 3350)
   - ○ Golytely (Split Prep)
   - ○ Enema
   - ○ Other _____

4. Time you last had liquids _____
   Date and time you last had solid food _____

5. For your safety, you will need a driver to bring you home after the procedure. What is the name and phone number of your driver or adult that will accompany?

   Name: _____ Phone Number _____

6. Are you taking any of the following anticoagulant or antiplatelet **medications:**
   - ◯ Enoxaparin (Lovenox)
   - ◯ Apixaban (Eliquis)
   - ◯ Coumadin (Warfarin, Jantoven)
   - ◯ Fondaparinux (Arixtra)
   - ◯ Dabigatran (Pradexa)
   - ◯ Dalteparin (Fragmin)
   - ◯ Rivaroxaban (Xarelto)
   - ◯ Edoxaban
   - ◯ Clopidogrel (Plavix)
   - ◯ Prasurgel (Effient)
   - ◯ Ticagrelor (Brilinta)
   - ◯ Ticoplidine (Ticlid)
   - ◯ Cilostazol (Pletal)
   - ◯ Dipyrimadole (Persantine)
   - ◯ Anagrelide (Agrylin)
   - ◯ Aspirin
   - ◯ NSAIDS
   - ◯ None of the above
   - ◯ Other _____

***If yes, you must check with your primary care clinician or prescribing physician 2 weeks before your procedure to adjust the dosage of the medications.**

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7. Do you take any medications for diabetes (insulin or a pill for diabetes)?
   ◯ Yes ◯ No

***If yes, you must check with your primary care clinician or prescribing physician 2 weeks before your procedure to adjust the dosage of the medications.**

8. Do you take any medications for pain management?
   ◯ Yes ◯ No
9. If you are having a **colonoscopy**, please review the following questions.

Question	**Answer**
Date of last colonoscopy?	
Personal history of adenomatous polyps?	◯ Yes ◯ No ◯ Unknown
Personal history of colon cancer?	◯ Yes, diagnosed in _____ (year) ◯ No
Family history of colon cancer? Check all that apply	◯ No ◯ Unknown ◯ Yes – Mother ◯ Yes – Father ◯ Yes – Brother ◯ Yes – Sister ◯ Yes – Grandmother ◯ Yes - Grandfather
Family history of polyps?	◯ Yes ◯ No ◯ Unknown
Personal diagnosis with Ulcerative Colitis?	◯ Yes, diagnosed in _____ (year) ◯ No
Personal diagnosis of Crohn's Disease?	◯ Yes, diagnosed in _____ (year) ◯ No

10. If you are having an **upper endoscopy (EGD),** please review the following questions.

Question	**Answer**
Date of last upper endoscopy (EGD)?	
Personal history of Barrett's esophagus?	◯ Yes, diagnosed in _____ (year) ◯ No
Personal history of GERD/acid reflux?	◯ Yes, diagnosed in _____ (year) ◯ No

11. Health History. Please check **Yes** or **No** for each condition.

Condition	**Yes**	**No**	**Condition**	**Yes**	**No**
Implanted Device/Metal	◯	◯	Bleeding Disorder	◯	◯
Chronic Obstructive Pulmonary Disease (COPD)	◯	◯	Hypertension/ Heart Disease	◯	◯
Asthma	◯	◯	Dialysis	◯	◯
Sleep Apnea (CPAP or BiPAP)	◯	◯	Fistula/catheter	◯	◯
Home O2 (oxygen)	◯	◯	HIV	◯	◯
Liver Disease (Hepatitis, Cirrhosis)	◯	◯	Seizure	◯	◯
Deep Vein Thrombosis (DVT)	◯	◯	Diabetes Mellitus	◯	◯
Pulmonary Embolism (PE)	◯	◯	Pregnant or Breastfeeding	◯	◯