

# Virginia Hospital Center

- Please fill in the following form, answering the questions to the best of your ability.
- If you have any questions, leave the space blank and we will answer them at the time of your interview.
- Please write any explanations or remarks in the space provided.
- Anything marked "Yes" should be explained further in the "Patient Explanation" space.

## General Information

Your Name:	Home Phone# :	Cell Phone#::
Age:	Work Phone#::	

Name of adult responsible for taking you home: Phone Number:
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What is the procedure you are having done?	Why are you having this procedure?
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Patient History (Place an "x" in the correct column)	Yes	No	Don't Know	Patient Explanation (Please write an explanation or attach a list)
1. Do you have any allergies to any medications, food (including seafood and fruit), or latex?				
2. Do you take any prescription medications?				Please List Current or Recent Prescription and Over-the-Counter Medications
3. Do you take any over-the-counter medications? Please list.				
4. Do you take antibiotics to protect your heart before dental procedures or surgery?				
5. Do you smoke? (Have you quit recently?)				
6. Do you drink alcoholic beverages? How many per week?				
7. Do you take recreational drugs?				
8. Have you ever had any heart problems?	Heart attack or heart blockage			
	Heart murmur or heart valve replacement or rheumatic fever			
	Chest pain or pressure			
	Congestive heart Failure			
	Irregular heart beat			
	Pacemaker or Internal Defibrillator			
9. Have you ever had any lung problems?	High blood pressure			
	Asthma			
	Sleep apnea/snoring			
12. Have you ever had any digestive tract problems?	Shortness of breath			
	Vomiting blood			
	Heartburn			
	Hiatal hernia			
	Ulcers			
	Difficulty swallowing			
	Abdominal pain			
	Change in bowel habits			
	Hepatitis			
	Jaundice			
Nutrition problems				

Addressograph

## GI Unit Patient History

Please turn to the reverse side to complete this form.

**OVER →**

<b>Patient History</b> (Place an "x" in the correct column)		<b>Yes</b>	<b>No</b>	<b>Don't Know</b>	<b>Patient Explanation</b> (Please write an explanation or attach a list)
10. Have you ever had any neurological problems?	Stroke				
	Seizures/epilepsy				
12. Have you ever had kidney failure?					
13. Do you have anemia?					
14. Do you have diabetes?					
15. Could you possibly be pregnant? Date of last menstrual period:					
16. Have you had any joint replacement surgery?					
17. Do you wear glasses or have a vision problem?					
18. Do you wear a hearing aid or have a hearing problem?					
19. Do you wear removable dentures?					
20. Are there any spiritual or cultural concerns that we should know about in taking care of you?					
21. Do you have a living will? Please bring a copy with you.					
22. Do you want information about creating a living will?					
23. Have you ever had major surgery, especially abdominal surgery? Please list.					
24. Do you have any other major medical problems that we need to know about? Please describe.					
Patient Signature:		Date:			