 Name - ______________________

INTEGUMENT (SKIN): rash, eczema, psoriasis, hair problems, nail problems, other.

____

EYES /EARS / NOSE / MOUTH: glasses, glaucoma, current vision problems, hearing loss, hearing aid, sinusitis, nose bleeds, hoarseness, tongue problems, other.

____

ANESTHESIA:

Do you have sleep apnea? ____

Do you have dentures? ____

Have you had any problems with anesthesia (sedation) in the past? (If yes, please explain). __________
____

ENDOSCOPY:

When was your last flexible sigmoidoscopy? (If applicable). ______________________

When was you last colonoscopy? (If applicable – please list date, doctor performing procedure, and findings). ____

When was your last EGD (Upper endoscopy)? (If applicable). ______________________

OTHER: Please list any other pertinent health information not already listed above.

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********The above information is true and correct to the best of my belief.**

____

Patient Signature and Date