Revised: 1/25/12

FOR REGISTRATION PURPOSES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Name: _____ **Birth Date:** _____

Address: _____ **Social Security #** _____

_____ **Phone Number:** _____

Marital status: never married / married / widowed / living as married / separated / divorced

Employment status: full time / part time / retired / self-employed / unemployed / active military

Employer: _____ **Religion:** _____

INSURANCE INFORMATION:

TYPE OF INSURANCE #1 _____ POLICY # _____
If you are not the subscriber, please provide us with the following information:

SUBSCRIBER NAME: _____ SUBCRIBER BIRTHDATE: _____

SUBSCRIBER SOCIAL SECURITY #: _____

Employment status: full time/part time/retired/self-employed/unemployed/active military

Employer: _____

TYPE OF INSURANCE #2 _____ POLICY # _____
If you are not the subscriber, please provide us with the following information:

SUBSCRIBER NAME: _____ SUBSCRIBER BIRTHDATE: _____

SUBSCRIBER SOCIAL SECURITY #: _____

Employment status: full time/part time/retired/self-employed/unemployed/active military

Employer: _____

If one of your insurances is Medicare please answer the following questions:

Do you receive Black Lung Benefits? Yes No
Do you take part in any research programs? Yes No
Is your procedure being covered by the Department of Veteran Affairs (DVA)? Yes No
Are you here due to an injury? Yes No
Did you receive your Medicare due to your age, a disability, or ESRD? _____
Are you currently employed? Yes No
If you are not employed, when was the last time you held a paying position? ___/___/_____
If you are married, is your spouse currently employed? Yes No
If your spouse is not employed, when was the last time he/she held a paying position? ___/___/_____

Name _____

ON THE DAY OF YOUR PROCEDURE:

- Complete this form and **bring it with you. Please do not mail.**
- If you have a Health Care Proxy please bring a copy with you.
- Drivers name and phone number _____

Primary Care Physician: _____ Current Weight: _____

Have you ever had a Flexible Sigmoidoscopy/Colonoscopy or Gastroscopy in the past?_____

Current complaints/symptoms _____

Hospitalizations/Surgeries (what & when) _____

_____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

Do you have?

☐ Diabetes—(If you check your blood sugar regularly, please check on day of appointment)
☐ A Pacemaker
☐ A Defibrillator
☐ Dialysis Shunt
☐ Organ Transplant
☐ Artificial heart valve
☐ Heart Valve Problem
☐ Immune Problem
☐ Anxiety
☐ Depression
☐ High Cholesterol
☐ High Blood Pressure
☐ Heart Disease _____
☐ Stroke
☐ Thyroid Problems
☐ Arthritis
☐ Asthma
☐ Lung Disease _____
☐ History of Cancer
☐ Liver Disease _____
☐ Hepatitis
☐ Kidney Disease
☐ Seizure Disorder
☐ Other _____
_____

Within the last 30 days have you had:

☐ Abdominal Aneurysm Graft
☐ Joint Replacement
☐ Coronary Stent
☐ Defibrillator Placed
☐ Pacemaker Placed

If yes, bring pacemaker identification card with you.
*Please let your Doctor know if you have a pacemaker or defibrillator prior to your appointment day.

Do you have a history of problems with anesthesia/ sedation? Yes No
If you answered yes, what are the problems? _____

Do you have a family history of any GI problems? List Age and Problem:

Father: _____ Mother: _____

Brother/Sister: _____

Smoking and Substance/ Alcohol History

Do you regularly use tobacco products? Yes-How much?_____ No Quit-- when?_____
Do you use recreational drugs? Yes No If yes…
What? _____ Date last used: _____
Do you drink alcoholic beverages? Yes No If yes…
What? _____ How much? _____ Date of last drink: _____

ENDOSCOPIC/MEDICAL PROCEDURES

Medication/Allergy List/ Reconciliation Form

MEDICATION LIST

- **Medications must be listed on this form, not on a separate piece of paper to be attached.**
- In order to serve you most efficiently, please list your **current medications**, and include any **over the counter medications, vitamins,** or **herbal supplements** you are taking. This includes all **aspirin,** and **anticoagulants** that you have stopped for this procedure.

Medication	Medication

Reconciliation Date: _____

History/Allergy/Medication Reconciliation Pre Procedure:

Reconciling MD Signature _____ Time_____

Reconciling Nurses Signature _____ Time _____

Unity Health System

MEDICATION/ALLERGY LIST/ RECONCILIATION FORM

ALLERGY FLAG

☐ **NO KNOWN ALLERGIES**

LIST ALLERGIES TO ANY MEDICATIONS.

FORM TO BE INITIATED AT ENTRY TO CARE.

PRESCRIBER	ALLERGY HISTORY ON ARRIVAL	
DRUG- FOOD- ENVIRONMENTAL INCLUDING LATEX	REACTION	PRESCIBER VERIFICATION
		❑ ALLERGY ❑ SENSITIVITY
		❑ ALLERGY ❑ SENSITIVITY
		❑ ALLERGY ❑ SENSITIVITY
		❑ ALLERGY ❑ SENSITIVITY
		❑ ALLERGY ❑ SENSITIVITY
		❑ ALLERGY ❑ SENSITIVITY
		❑ ALLERGY ❑ SENSITIVITY
		❑ ALLERGY ❑ SENSITIVITY

LATEX SCREENING:

Do you have an allergy to latex or rubber products? ☐ Yes ☐ No

If yes, what is the reaction?_____

Have you had hives, rashes, swelling or trouble breathing after contact with rubber products, like balloons, gloves, band-aids, elastic waistbands or condoms? ☐ Yes ☐ No

Have you ever experienced itching, swelling or other symptoms, after dental, rectal, or pelvic exams? ☐ Yes ☐ No

Are you allergic to bananas, avocados, or water chestnuts? ☐ Yes ☐ No