

**Murray Hill Medical Group Office Based Endoscopy**  
**PRE-PROCEDURE EVALUATION**

Name:

Age:

Referring Physician:

Reason for Procedure:

Past Surgical History:

Past Medical History:

Past Hospitalizations:

OB/GYN History:

Medications Currently Taking:

Allergies To Medications Or Foods:

Social History (cigarette use, alcohol intake, marital status, job):

Family History:

Other important information:

- 1) Have you ever had any problems with bleeding?
- 2) Do you have any heart disease?
- 3) Do you have any respiratory problems?
- 4) Are you taking any aspirin, anti-inflammatory medication, or blood thinners of any type?
- 5) Have you had any problems with anesthetics/sedatives in the past?

\_\_\_\_\_  
Patient Signature

Date:\_\_\_\_\_