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?

________________________________ Date:______________________
Patient Signature