

Endoscopy Center of the Rockies

Patient Health History & Medication Reconciliation Form

Patient Name: _____ Date of Birth: ____/____/____

Primary Doctor: _____

Referring Doctor (if not your primary doctor): _____

Primary Care Provider Office Phone #: _____

Reason for procedure: _____

Health History

Prior Colonoscopy: Date: ____/____/____ Findings: _____

Heart Disease/Disorders:

- High Blood Pressure
- History of MI (heart attack)
- Arrhythmia: _____
- Leaky/Prolapsed Valves
- Other: _____

Lung Disease/Disorders:

- Asthma
- COPD
- Sleep Apnea
- Oxygen use at home: (when & liters used)

- Other: _____

Gastrointestinal Disease/Disorders:

- Colonic Polyps
- Personal History of Intestinal Cancer
- Ulcerative Colitis
- Barrett's Esophagus
- Dysphagia (Difficulty Swallowing)
- GERD
- Other: _____

Family History of Colon Cancer or Colon Polyps:

- Colon Cancer (Relation & Age at Diagnosis)

- Colon Polyps (Relation & Age at Diagnosis)

Implanted Medical Devices:

- Pacemaker
- Defibrillator
- Plates/Pins/Screws/Rods
- Artificial Joint(s): _____

Other Health History: _____

Diabetes: (Treatment)

- Insulin
- Oral Medication
- Diet
- Most recent blood glucose & date/time

Bleeding or Clotting Disorders:

Infectious Disease:

- HIV
- Hepatitis (B or C)
- Tuberculosis
- Other: _____

Pregnancy Status: (if applicable)

- Pregnant
- Hysterectomy
- Post Menopause
- Denies Pregnancy (LMP): _____

Surgical History:

- Hysterectomy
- Appendectomy
- Cholecystectomy
- Other: _____

Social History:

- Alcohol
- Tobacco
- Recreational Drugs/Medical Marijuana: _____



Boulder: 1755 48th St
Lafayette: 1000 W. S Boulder Rd
Longmont: 1551 Professional Ln