## Endoscopy Health History Form Please fill out this form and bring it with you to your appointment.

Pre-Visit Information							
Name: DOB: Reason for Procedure:							
Prep taken: □ Nulytely □ Miralax & Gatorade □ Magnesium Citrate □ Dulcolax □ Other:							
Prep Results: □ Clear □ Tea Color □ Brown Liquid □ Other							
Driver Information							
Name: Relationship: Phone: If patient is less than 18 years old and driver is someone other than a parent or guardian, please visit www.mngi.com/forms to print and complete the Unaccompanied Minor Patient Authorization Form.							
Medical History							
Height:		Weight:					
Heart Disease: ☐ Ye	s 🗆 No	Kidney Disease/Dialysis	□ Yes	□ No			
Respiratory Problems:	S □ No nea	Diabetes:	□ Yes	□ No			
High Blood Pressure: ☐ Ye	s 🗆 No	Seizures/Fainting:	□ Yes	□ No			
Hepatitis: ☐ Ye	s □ No	Pregnant/Nursing:	□ Yes	□ No	□ NA		
History of Anesthesia Problems: □ Yes □ No If Yes, please describe:							
Past Surgical Procedures:							
Have you had an upper respiratory infection or asthma flare within the last week? $\square$ Yes $\square$ No If yes, please call our office prior to starting procedure prep							
An important risk for colon cancer is family history. The following questions can help your physician determine your risk.							
PERSONAL HISTORY							
Have you ever had a colonoscopy?  If Yes when and where?	Date/	/ Location	□ Yes	□ No			
Have you ever had colorectal cancer	?		□ Yes	□ No			
Have you ever had precancerous col		□ Yes	□ No				
Do you have inflammatory bowel di Crohn's Disease or Ulcerative Colitis		□ Yes	□ No				
FAMILY HISTORY (This information is for blood relatives only)							
Do you have a first-degree relative (parent, sibling, child) who had precancerous polyp(s) before age 60?							
			□ Yes	□ No	□ Unknown		

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(parent, sibling, chile	d, aunts, uncles, cousins	, grandparent) who have had				
		□ Yes □ No □ Unknown				
es (parent, sibling, o	child) who have been di					
Dogo/Ethrici	etr/Dischilition	☐ Yes ☐ No ☐ Unknown				
Race/Etimici	ity/Disabilities					
□Black or Africa	n American	□Latino or Hispanic				
□Native Hawaiia	n or other	□White				
□Pacific Islander		□I do not wish to disclose				
Do you have any disabilities which affect your memory or learning?						
Medications, Allergies and Reactions (Include Over the Counter/Herbal medications)						
	Reactions:					
		_				
Dosage	Frequency	Last Taken				
Dosage	Frequency	Last Taken				
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	g, child) who had co  (parent, sibling, child  ves (parent, sibling, child  Race/Ethnici  Black or Africa  Native Hawaiia  Pacific Islander  affect your memory	and Reactions (Include Over the Counter				