PREMIER
SPECIALTY PHYSICIANS
G.I. AND LIVER

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Patient Name: _____ DOB: _____

Allergies: _____

PLEASE MARK IF YOU HAVE EVER BEEN DIAGNOSED WITH THE FOLLOWING:

__ Hepatits A, B, C __ Pancreatitis __ Cirrhosis __ Jaundice __ Kidney Disease __ Kidney Stones __ High Blood Pressure

__ Heart Attack __ Heart Murmur __ Congestive Heart Failure __ Diabetes __ Emphysema __ Asthma __ Bronchitis __ COPD

__ Pneumonia __ Sleep Apnea __ Stroke __ Paralysis __ Blood in Urine __ Thyroid Disease __ Anemia __ Leukemia

__ Bleeding / Clotting Disorder __ Anxiety __ Depression __ Suicide Attempt __ Cancer (type) _____

PLEASE LIST OTHER CHRONIC CONDITIONS:

_____
_____
_____

Have you ever had a reaction to anesthesia? Y N

If so, what was the reaction: _____

DO YOU CURRENTLY TAKE A BLOOD THINNER (INCLUDING ASPIRIN)? Y N

If yes, name of medication: _____ who monitors it? _____

PROCEDURES: PLEASE LIST DATE, ORDERING PHYSICIAN AND/OR HOSPITAL

Colonoscopy: date _____ **Physician:** _____ **Hospital:** _____

EGD: date _____ **Physician:** _____ **Hospital:** _____

Liver Biopsy: date _____ **Physician:** _____ **Hospital:** _____

SURGERIES: PLEASE LIST ALL SURGERIES, NAME OF SURGEON, HOSPITAL

_____
_____
_____
_____
_____
_____
_____
_____