

Maryland Endoscopy Center, L.L.C.
100 West Road, Suite 115
Towson, Maryland 21204

6. For Women: Are you pregnant? No Yes Date of last menstrual period: _____

7. Do you have any hearing, visual or physical impairment?
 No Yes Explain _____

8. Check if you have ever had any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Reflux Esophagitis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Esophageal Stricture |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Barrett's Esophagus |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Polyps of the stomach |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Colon Polyps |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Diverticulosis/Diverticulitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Irritable Bowel / Spastic Colon |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ostomy |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Liver Problems (Hepatitis) | <input type="checkbox"/> Family History of Colon Cancer or Polyps |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Personal History of Colon Cancer |
| | <input type="checkbox"/> Other _____ |

9. List **SURGERIES** and the **YEARS** in which you had these done:

10. Have you had any problems with intravenous sedation or anesthesia?
 Yes No Describe _____

11. Check if you use any of the following:
Alcohol Yes No Quantity per day _____
Tobacco Yes No Quantity per day _____
Narcotics Yes No Quantity per day _____

12. We will call to check up on you the next business day after your procedure. If you are not at home, can we leave a message on your answering machine or speak with whomever answers your phone? Yes No. If not, what is an alternate phone number where you may be reached? _____

13. Do you have Advance Directives, i.e., Living Will, etc., in place now? Yes No