5801 Norris Canyon Road, Ste. 220 San Ramon, CA 94583
Phone: 925.275.9966 Fax: 925.275.9915

NOTICE TO OUR PATIENTS

PLEASE READ BEFORE COMING IN FOR A PROCEDURE

*Please **expect to sign and/or fill** out 3-4 pages of information when coming in for a procedure. Please bring your reading glasses if you need them.

*Please bring your **Primary Physician**'s full name and phone number.

*Please have your **insurance card** and **driver's license** ready to show at the time of check in.

*Please have the "**Health Questionnaire**" filled out before coming in for your procedure along with the most current **list of medications.**

*A ***DRIVER is REQUIRED*** **to accompany** you into the San Ramon Endoscopy Center and ***sign in*** with the front desk. If your driver does not come up and sign in, we cannot perform your procedure due to patient safety and liability issues.

*You can have two different drivers. Have the driver that drops you off sign you in and we can call the driver that will pick you up right after your procedure.

*Your driver may leave right after they sign in. One of the nurses will call them approximately 1-2 ½ hours from the check in time.

***ABSOLUTELY NOTHING TO DRINK OR EAT AFTER MIDNIGHT THE DAY BEFORE OF YOUR PROCEDURE.** (You make take your morning medications with a tiny sip of water **if you have to.**)

Endoscopy Center
5801 Norris Canyon Road 8220
San Ramon, CA 94583 USA

Please fill our completely and bring to your first visit.

Name: ______________________ Who may we thank for referring you? ____________

Reason for this Visit: ______________________ Age: ______ Height: ______ Weight: ______

Medical Problems-Hospitalization-Surgeries

	Date:		Date:
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Allergies: ☐ None, Allergies to: ☐ Latex ☐ Iodine/Shellfish ☐ Anesthetic ☐ Medications: ____________

Medications: (Include BCP, calcium, vitamins, aspirin, herbs)

Medication	Dosage	Medication	Dosage

Social History: Occupation: ____________ ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other ______

Smoker ☐NO ☐YES, I smoke approximately _____ Pack(s) a Day for ______ Years. Alcohol ☐NO ☐YES, I have approximately _____Drinks a Day.

Family:

	Age	Medical Problems	Deceased		M	F	Age	Medical Problems	Deceased
Father			☐	Children	☐	☐			☐
Mother			☐	Children	☐	☐			☐
Brother/Sister			☐	Children	☐	☐			☐
Brother/Sister			☐	Children	☐	☐			☐
Brother/Sister			☐	Children	☐	☐			☐

Review of Systems: (Please check all that apply) Last Menses: ________ Birth Control Method: ________

I have: ☐ Pacemaker ☐ Mastectomy ☐ Dentures ☐ Eyeglasses ☐ Hearing Aid ☐ ____________

☐ Diabetes ☐ High blood pressure ☐ Heart Failure ☐ Organ Transplant ☐ Valve Replacement ☐ Courmadin/Warfin use

I have:

	Past	Current
Constitutional		
Fever	☐	☐
Weight Changes	☐	☐
Fatigue/Weakness	☐	☐
HEENT/Neurology		
Headaches	☐	☐
Seizure/Strokes	☐	☐
Eye Problems	☐	☐
Hearing/Ear Problems	☐	☐
Respiratory		
Shortness of breath	☐	☐
Asthma/Emphysema	☐	☐
Pneumonia/Bronchitis/TB	☐	☐
Sleep Apnea	☐	☐
Cardiology		
Chest Pains	☐	☐
Heart Attack	☐	☐
Rheumatic Fever/Mumur	☐	☐
Antibiotics before dentist	☐	☐
Leg Swelling or Cramps	☐	☐

	Past	Current
Endocrine		
Thyroid Problems	☐	☐
Hematology/Oncology		
Anemia/Transfusion	☐	☐
Bleeding/Clotting Disorders	☐	☐
Immune Deficiency	☐	☐
Cancer	☐	☐
Rheumatology		
Arthritis/Joint Pains	☐	☐
Immune Disorders	☐	☐
Immune Deficiency	☐	☐
Cancer	☐	☐
Urology		
Prostate Problems	☐	☐
Urinary Infections	☐	☐
Kidney Stones	☐	☐
Blood in Urine	☐	☐
Psychology		
Suicide Attempts	☐	☐
Drug/Alcohol Abuse	☐	☐

	Past	Current
Gastroenterology		
Nausea	☐	☐
Vomiting	☐	☐
Heartburn/Regurgitation	☐	☐
Difficulty Swallowing	☐	☐
Ulcers	☐	☐
Hepatitis/Jaundice/Liver Dis	☐	☐
Gallstones	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Bloody/Black Stools	☐	☐
Diverticulosis or Diverticulitis	☐	☐
Abdonimal discomfort/pain	☐	☐

DATE: ____________ PATIENT SIGNATURE: ______________________

Reviewed & Updated ____________ ______________________
DATE PATIENT SIGNATURE