Dr. Simon Cofrancesco
Dr. Sergio Quijano
Dr. Tyler An
Erin Yard, FNP

Medical History Form

Patient's Name____

Date of Birth___/___/_____ Height_______ Weight________ Any Allergies?____________________

Primary Care Doctor:____

Who referred you to our office:____

Your medications and the dose	**Why do you take this medication?**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Blood Thinner: Are you on a blood thinner?______________ When did you take it last?______________

Gastrointestinal History--- Please check all that apply to you:

Why are we seeing you?____

• Heart burn/Refux • Colon Cancer---date of Diagnosis_____________ • History of Colon Polyps

• Family history of Colon Polyps or Colon Cancer? • Mother • Father • Sibling • Grandparent

Heart History-Please check all that apply to you: • None of these apply to me

• Heart attack---when?_____________ • Heart Stents---when?____________

• Pacemaker or Defibrillator (circle one) • Heart Failure • High Blood Pressure

• Chest Pain (check one) • When I'm up moving around

• When I'm laying down • My chest pain is unpredictable.

Lung History-Please check all that apply to you: • None of these apply to me

• Asthma---Have you ever gone to the hospital for Asthma? When?______________________________

• Smoking---How many cigarettes do you smoke per day?__________For how many years?__________

• Sleep Apnea--- Do you have a CPAP machine?____________________ Do you use it?______________

Neuro History-Please check all that apply to you: • None of these apply to me

• Stroke---when_____________) • Seizures---When was the last one?_________________________

• Anxiety (mild/moderate/severe) • Depression • Alcohol---How many drinks per day?________

Renal/Endocrine History---Please check all that apply to you: • None of these apply to me

• Diabetic---Do you take Insulin? Yes/No (please circle one) • Dialysis

• Are you Pregnant? • Could you be pregnant?* • Date of last Menstrual Cycle_________

Surgeries (please list the date as well): • I've never had surgery

____

____

Have you ever had problems with Anesthesia? ____

Has anyone in your family had problems with Anesthesia?______________________________________

Do you have an egg allergy?____

*You will have the option to either take a pregnancy test before your procedure or sign a pregnancy release form stating you are not pregnant. If you have any questions about this, or any other question related to this form, please call 404-446-0600