Northwell Health℠ | ECLI
711 Stewart Avenue, Garden City, NY 11530
T: 516-227-3254(ECLI) **F:** 516-998-4078

NAME:
DOB:
MRN:
PHYSICIAN:

PATIENT MEDICAL HISTORY:

Patient Name:	DOB:	Height:	Weight:

Please Indicate Yes or No: (If yes, please specify)

Question	Yes	No
Are any of your teeth weak, loose or broken?	☐	☐
Are you allergic to any medications, latex, soy, sulfites, eggs, or peanuts?	☐	☐
Do you take any drugs for recreational (non medical) use?	☐	☐
Do you drink alcoholic beverages daily or frequently?	☐	☐
Do you currently smoke cigarettes?	☐	☐
If NO, did you previously smoke and quit? If so, when did you quit?		

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? Please Indicate Yes or No:

Condition	Yes	No	Condition	Yes	No
High blood pressure	☐	☐	Hiatal hernia / gastroesophageal reflux	☐	☐
Valvular heart disease	☐	☐	Kidney disease / prostate disease	☐	☐
Irregular heartbeat	☐	☐	Diabetes	☐	☐
Coronary artery disease	☐	☐	Thyroid disease	☐	☐
Heart attack	☐	☐	Convulsions / epilepsy / seizures	☐	☐
Chest pain/ angina	☐	☐	Stroke / paralysis / arm or leg weakness	☐	☐
Cardiac stent	☐	☐	Depression / anxiety	☐	☐
Permanent pacemaker	☐	☐	Arthritis	☐	☐
AICD	☐	☐	Bleeding / bruising easily	☐	☐
A cold at present / frequent cough / sputum	☐	☐	Liver disease / jaundice / hepatitis: (A , B , C)	☐	☐
Asthma / emphysema	☐	☐	High cholesterol/lipid	☐	☐
Sleep Apnea	☐	☐	If YES, CPAP used? N☐ Y☐ If Yes, CPAP #:		
Cancer	☐	☐	If YES, where?		
Complication w/ Anesthesia?	☐	☐	If YES, what?		
WOMEN ONLY: Period within last year?	☐	☐	Any other serious illness?	☐	☐

Do you wear any or all of the following?
Please Indicate Yes or No:

Glasses? **Y** ☐ **N** ☐ Contact Lenses? **Y** ☐ **N** ☐
Hearing aid? **Y** ☐ **N** ☐ Dentures? **Y** ☐ **N** ☐

List all previous procedures in which you received anesthesia within the past 24 months:

☐	I was instructed not to eat, drink, or take any medications (unless specified by my physician - IE Colon Prep) after midnight last night and I have followed those instructions.
☐	I have made arrangements to have a responsible adult drive me home. I understand that I will not be released unescorted or accompanied only by a minor. I do not plan to drive or even take a taxi alone.
☐	I acknowledge that the Endoscopy Center of Long Island is not responsible for valuables I have elected to bring with me.

Name of Escort:	Phone:	Do we have permission to discuss your personal health with your escort? Y: ☐ N: ☐

IF YOU TAKE ANY PRESCRIPTION OR OVER THE COUNTER MEDICATIONS OR HERBAL PREPARATIONS, PLEASE WRITE THE NAMES, STRENGTHS, AND HOW OFTEN THEY ARE TAKEN ON THE MEDICATION RECONCILIATION FORM.

Signature of Patient: _____ **Date:** _____

Signature of Anesthesiologist/CRNA: _____ **Date:** _____