

First Name _____ Last Name _____ DOB/Age _____
 Ht. _____ Wt. _____ Allergies _____ PT# (Internal) _____

REASON FOR EXAM (Please include symptoms and time frame):

TECH NOTES (for internal use only):
 Has the patient eaten Yes No
 Previous Endoscopy findings:

Additional tech notes:

Previous Imaging Studies Related to Todays Exam	Date
Previous Surgeries Related to Todays Exam	Date

Have you ever had any of the following procedures in the past (if yes, please indicate when):

Esophageal surgery Yes No _____ Small bowel surgery Yes No _____
 Stomach surgery Yes No _____ Upper Gastrointestinal exam or Esophagram Yes No _____

Are you currently experiencing or have you ever been diagnosed with any of the following:

Food or liquid Aspiration Yes No If yes, how long? _____
 Difficulty Swallowing Yes No If yes, how long? _____
 Nausea Yes No If yes, how long? _____
 Vomiting Yes No If yes, how long? _____
 Blood or Bile in Vomit Yes No If yes, how long? _____
 Hiatal Hernia Yes No If yes, when? _____
 Bowel Obstruction Yes No if yes, when? _____
 Ulcers Yes No if yes, location: _____ When? _____
 Small bowel or Colon Polyps Yes No if yes, Removal date: _____
 Cancer Yes No If yes, Please Explain: _____
 Family History of Cancer Yes No If yes, Please Explain: _____
 Other important medical conditions: _____

Current Medications:

I agree that the above information is correct (Do not fill out until after technologist has reviewed):

Patient Signature: _____ Todays Date: _____