

EGD

Patient's Name _____ DOB _____

Today's Date _____ Age _____

Patient is referred by _____

- Patient's History* is positive for:
- _____ Ulcers
 - _____ Gastritis
 - _____ GERD
 - _____ Hiatal hernia
 - _____ Dysphagia
 - _____ Choking
 - _____ Hematemesis
 - _____ Nausea/vomiting
 - _____ Pain with swallowing
 - _____ Unexplained weight loss
 - _____ Blood in stool
 - _____ Abdominal pain
 - _____ Any testing

_____ Previous abdominal surgery

_____ Caffeine use _____ Tobacco use _____ PPD

_____ ETOH use

_____ Pacemaker/defibrillator

_____ Blood thinners

Current medications for this condition _____

Prescribed by _____

The patient has never had an upper endoscopy _____ Has had EGD _____ years ago.