Olean General Hospital
A Member of Upper Allegheny Health System

Please answer these questions concerning your health status. All information is confidential. Thank you.

ENDO Health History - please print -

Name: _____ Age: _____ E-mail: _____

What is the main reason for your visit to the hospital? _____

Family Doctor's Name: _____

Current Medications and Dose ☐None

Drug	Strength	How Often	Last Dose

Drug	Strength	How Often	Last Dose

Major Operations ☐None

What was done? **About when?**

_____

_____

_____

Allergies to Medications ☐None

_____

_____

_____

Have you ever had a reaction or sensitivity to latex?
☐ Yes ☐No

Family Health History

Do these problems run in your family?

	Father	Mother	Other
Cancer	☐	☐	☐
Colon Cancer	☐	☐	☐
Colon Polyps	☐	☐	☐
Ulcer Disease	☐	☐	☐
Gallbladder Disease	☐	☐	☐
Ulcer Colitis	☐	☐	☐
Crohn's Disease	☐	☐	☐

- - - FOR NURSE USE ONLY - - -

Height: _____
Weight: _____
Blood Sugar: _____
Heart Sounds: _____
Lung Sounds:_____
Exposure to Cont. Diseases: _____
Vital Signs - Admission:
T: _____ P:_____ R:_____ Sa02: _____
Bowel Prep _____
NPO _____

Please answer questions on page 2

Study of Symptoms

Please check the boxes of those conditions that affect you.

Head

- ☐ Removable Bridge
- ☐ Glaucoma
- ☐ Wear Hearing Aid
- ☐ Wear Dentures
- ☐ Loose Teeth

Blood

- ☐ Blood Transfusion in last 6 months
- ☐ Prolonged bleeding from surgery
- ☐ Anemic in Past
- ☐ Ever Treated for Cancer
- ☐ Think I am at risk for AIDS

Heart and Lungs

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Heart Attack in Past
- ☐ Fainting Spells
- ☐ Irregular Heartbeat
- ☐ Wear Pacemaker
- ☐ Shortness of Breath
- ☐ Awaken Short of Breath
- ☐ Ankles Swell
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve
- ☐ Rheumatic Fever as a Child

Brain

- ☐ Epilepsy or Seizures
- ☐ Past Strokes

Digestive Tract

- ☐ Poor Appetite
- ☐ Frequent Heartburn
- ☐ Heartburn Awakens
- ☐ Trouble Swallowing
- ☐ Hiatal Hernia in Past
- ☐ Rectal Bleeding
- ☐ Black Bowel Movements
- ☐ Vomited Blood
- ☐ Ulcers in Past
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Lost Bowel Control or Soiling
- ☐ Constipation
- ☐ Bowel Habit Unpredictable
- ☐ Colon Polyps in Past
- ☐ Liver Disease of Jaundice

Women Only

- ☐ Pregnant Now
- ☐ Planning Pregnancy

Health Habits

- ☐ Unexpected Weight Loss
- ☐ Fever or Shaking Chills
- ☐ Take Coumadin, Blood-thinners, Plavix

Please answer each question by checking the appropriate box.

Do you:

☐Yes ☐No Smoke cigarettes? _____ packs a day.

☐Yes ☐No Chew tobacco?
How much?_____

☐Yes ☐No Drink beer? _____ bottles per _____

☐Yes ☐No Drink wine?
_____ oz. per _____

☐Yes ☐No Drink hard liquor?
_____ oz. per _____

☐Yes ☐No Use aspirin, ibuprofen, or blood thinners?
How often? _____