

GASTROENTEROLOGY HEALTH QUESTIONNAIRE

PLEASE COMPLETE THIS FORM IN PEN AND BRING IT WITH YOU ON THE DAY OF YOUR PROCEDURE.

IF YOU HAVE A HEALTHCARE PROXY, OR LIVING WILL, PLEASE BRING A COPY WITH YOU FOR OUR MEDICAL RECORD.

Addressograph

Standard Register ©

1. Name: _____ Birthdate: _____

2. IF YOU ARE BEING SEDATED, YOU MUST HAVE A RESPONSIBLE ADULT TO DRIVE YOU HOME

Driver's Name: _____

In waiting room

Please call driver - phone number: _____

Driver will return at (time): _____

Please instruct your driver to come to the second floor Ambulatory Procedure Center (APC), by the yellow elevators, to receive discharge instructions and to escort you to the car.

You can take a taxi ONLY if you have a responsible adult to escort you. We do not consider the taxi driver your escort. Taking a bus home is not acceptable. IF YOU DO NOT HAVE SOMEONE TO DRIVE YOU HOME, YOUR PROCEDURE WILL BE CANCELLED.

3. Do you speak and/or understand English? Yes No

If you do not speak English, you are welcome to bring someone to help you or let us know in advance so we can make arrangements for an interpreter.

4. What medical problems/symptoms are you having that require you to have this procedure? _____, or is this a colon screening? Yes No

5. Is there a history of colon cancer in your family? Yes No

If Yes, what is their relationship to you? _____

6. Please check the following that apply to you (the patient):

- | | | |
|--|---|---|
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Colitis, Crohn's disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Irritable bowel syndrome |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart attack, angina | <input type="checkbox"/> Diverticulosis/Diverticulitis |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart Valve Replacements | <input type="checkbox"/> Gastric ulcers |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Barrett's esophagus |
| <input type="checkbox"/> Dialysis shunt, mediport | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Liver Cirrhosis/Jaundice |
| <input type="checkbox"/> Asthma, emphysema | <input type="checkbox"/> Ileostomy | <input type="checkbox"/> GERD (Gastroesophageal Reflux Disease) |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Colostomy | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Joint replacements/prosthesis | <input type="checkbox"/> History of colon polyps | |
| <input type="checkbox"/> Pacemaker/Defibrillator (bring medical alert card) | <input type="checkbox"/> Drink alcohol, frequency _____ | |
| <input type="checkbox"/> Tobacco, type _____ | <input type="checkbox"/> Recreational drugs, name _____ | |
| <input type="checkbox"/> Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | | |
| | Last menstrual period: _____ | |
| <input type="checkbox"/> Other: | | |

7. List all surgeries you have had, and when you had them: _____

