Pre-Procedure Medical Questionnaire

Name _____DOB_____

Requested Procedure(s) EGD COLONOSCOPY FLEX SIG

Reason for Procedure_____

Do you have a cardiologist? Who?	☐ Y ☐ N
Have you seen your cardiologist in the last 6 months?	☐ Y ☐ N
Have you been told that you have Aortic Stenosis?	☐ Y ☐ N
Do you have an AICD/defibrillator/shock device in your heart?	☐ Y ☐ N
Do you have stents in your heart?	☐ Y ☐ N
Are you currently having a problem with chest pain?	☐ Y ☐ N
Do you have high blood pressure?	☐ Y ☐ N
Do you have any heart or lung tests scheduled in the near future?	☐ Y ☐ N
Have you been told that you have pulmonary hypertension?	☐ Y ☐ N
Are you on home oxygen?	☐ Y ☐ N
Has a doctor ever told you that your airway is difficult to intubate?	☐ Y ☐ N
Do you have severe TMJ causing difficulty opening your mouth?	☐ Y ☐ N
What is your height?	
What is your weight?	
Are you on Dialysis?	☐ Y ☐ N
Do you have a severe latex allergy which has caused breathing problems or required medical attention?	☐ Y ☐ N
Are you on Blood Thinners?	☐ Y ☐ N
• Anti-platelet medications: such as Plavix (also known as Clopidogrel), Effient, and Brillinta	☐ Y ☐ N
• Anti-coagulant medications: such as Coumadin, Warfarin, Pradaxa, Xarelto, and Eliquis	☐ Y ☐ N
Have you had any type of cancer besides skin?	☐ Y ☐ N
If you have cancer, do you currently have a chemotherapy port?	☐ Y ☐ N
Are you diabetic?	☐ Y ☐ N
If YES, are you on insulin?	☐ Y ☐ N
Have you had surgery on your ABDOMEN?	☐ Y ☐ N

If YES, for what?	
Do you take any prescription medication for anxiety, depression, bipolar disease or psychiatric disorder?	☐ Y ☐ N
Do you have a parent, brother or sister who has had colon cancer?	☐ Y ☐ N
Do you have a parent, brother or sister who has had stomach cancer?	☐ Y ☐ N
Have you had a colonoscopy in the past?	☐ Y ☐ N
If YES, approximately what year?	☐ Y ☐ N
Have you had an endoscopy/EGD in the past? What year?	☐ Y ☐ N
Does food get stuck in your esophagus when you swallow?	☐ Y ☐ N
Do you experience heartburn?	☐ Y ☐ N
If YES, do you take medication for it daily?	☐ Y ☐ N
If you take medication daily for heartburn, does it control your symptom most of the time?	☐ Y ☐ N
Do you experience frequent abdominal pain?	☐ Y ☐ N
Do you experience frequent diarrhea?	☐ Y ☐ N
If YES, have you been having diarrhea for more than 3 months?	☐ Y ☐ N
Do you experience frequent constipation?	☐ Y ☐ N
If YES, have you been having constipation for more than 3 months?	☐ Y ☐ N
Do you ever see blood mixed in with your stool?	☐ Y ☐ N
If Yes, has this happened more than 5 times?	☐ Y ☐ N