Pre-Procedure Medical Questionnaire

Name_____DOB_____

Requested Procedure(s) EGD COLONOSCOPY FLEX SIG

Reason for Procedure_____

1. Do you have a cardiologist? Who?	☐ Y ☐ N
2. Have you seen your cardiologist in the last two years? If so, why?	☐ Y ☐ N
3. If it has been more than two years since your last cardiology visit, do you have any ongoing cardiac issues that require a doctor's supervision?	☐ Y ☐ N
4. Do you have an AICD/defibrillator/shock device in your heart?	☐ Y ☐ N
5. Do you have a pacemaker?	☐ Y ☐ N
6. Are you on Blood Thinners? Who prescribes?	☐ Y ☐ N
6a. Anti-platelet medications: such as Plavix (also known as Clopidogrel), Effient, and Brillinta	☐ Y ☐ N
6b. Anti-coagulant medications: such as Coumadin, Warfarin, Pradaxa, Xarelto, and Eliquis	☐ Y ☐ N
7. Do you have stents in your heart?	☐ Y ☐ N
8. Are you currently having a problem with chest pain?	☐ Y ☐ N
9. Do you have any heart or lung tests scheduled in the near future?	☐ Y ☐ N
10. Are you on home oxygen?	☐ Y ☐ N
11. Has a doctor ever told you that your airway is difficult to intubate?	☐ Y ☐ N
12. Do you have trouble with mobility or require a wheel chair or stretcher?	☐ Y ☐ N
13. Do you have severe difficulty opening your mouth?	☐ Y ☐ N
14. What is your height? BMI?	
15. What is your weight? Airway Check?	☐ Y ☐ N
16. Are you on Dialysis? If yes, what days (Circle)? **M T W R F S Su**	☐ Y ☐ N
17. Have you had any type of cancer besides skin?	☐ Y ☐ N
18. If you have cancer, do you currently have a chemotherapy port?	☐ Y ☐ N
19. Are you diabetic?	☐ Y ☐ N
19a. If yes, are you on insulin?	☐ Y ☐ N

20. Have you had surgery on your abdomen?	☐ Y ☐ N
20a. If yes, for what?	
21. Do you take any prescription medication for anxiety, depression, bipolar disease or psychiatric disorder?	☐ Y ☐ N
22. Do you have a parent, brother or sister who has had colon cancer?	☐ Y ☐ N
23. Do you have a parent, brother or sister who has had stomach cancer?	☐ Y ☐ N
24. Have you had a colonoscopy in the past?	☐ Y ☐ N
24a. If yes, approximately what year?	
25. Have you had an endoscopy / EGD in the past?	☐ Y ☐ N
25a. If yes, what year?	
26. Does food get stuck in your esophagus when you swallow?	☐ Y ☐ N
27. Do you experience heartburn?	☐ Y ☐ N
27a. If yes, do you take medication for it daily?	☐ Y ☐ N
27b. If you take medication daily for heartburn, does it control your symptoms most of the time?	☐ Y ☐ N
28. Do you experience frequent abdominal pain?	☐ Y ☐ N
29. Do you experience frequent diarrhea?	☐ Y ☐ N
29a. If yes, have you been having diarrhea for more than 3 months?	☐ Y ☐ N
30. Do you experience frequent constipation?	☐ Y ☐ N
30a. If yes, have you been having constipation for more than 3 months?	☐ Y ☐ N
31. Do you ever see blood mixed in with your stool?	☐ Y ☐ N
31a. If yes, has this happened more than 5 times?	☐ Y ☐ N

Internal Use Only

- * Do * take Blood Pressure medicine on day of the test
- BMI of 45 – 50 needs airway check
- BMI > 50 **cannot** go to Endo Center

Scheduler Name / Initials _____