Please complete this medical questionaire to provide information necessary to meet your specific needs during your stay.
If you have been here before we have your records. Please update if there are any changes. A nurse will gladly assist you as needed.
This information is confidential. Your nurse and physician will review this and ask additional questions as needed for clarification.

PATIENT QUESTIONAIRE

SECTION I

HEIGHT	WEIGHT	ADMITTING DIAGNOSIS / CHIEF COMPLAINT: Why Do You Need Test?	Procedure Planned ❑ EGD ❑ Colonoscopy ❑ Other _____

I HAVE A RESPONSIBLE PERSON TO TAKE ME HOME AND BE RESPONSIBLE FOR MY CARE AFTER DISCHARGE, HIS/HER NAME IS:
❑ Waiting
❑ To Be Called

Phone Number
( ) _____ - _____
( ) _____ - _____

Time Available
❑ AM
❑ PM ❑ Any Time

ARE YOU ALLERGIC TO MEDICINES? ❑ NO ❑ YES *(LIST)* _____

HAVE YOU HAD ANESTHESIA BEFORE ? ❑ NO ❑ YES
ANY BAD REACTIONS? - Please List: _____

CHECK (✓) IF ALLERGIC TO:
❑ TAPE ❑ LATEX

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING (BOTH PRESCRIPTION AND NON-PRESCRIPTION) including Eye Drops

CURRENT MEDICATIONS	DOSAGE	TIME LAST TAKEN	CURRENT MEDICATIONS	DOSAGE	TIME LAST TAKEN
1.			5.		
2.			6.		
3.			7.		
4.			8.		

IF DIABETIC, LAST BLOOD SUGAR RESULT: _____ Date: _____ Time: _____ ❑ AM ❑ PM ❑ NOT KNOWN

Please check (✓) the following that apply to **you**.

Cardiac: ❑ High Blood Pressure ❑ Heart Disease ❑ Pacemaker/ AICD ❑ Heart Valve Replacement
❑ Angina/Coronary Artery Disease/Chest Pain ❑ Heart Murmur or Mitral Valve Prolapse ❑ Irregular Heart rate:

Respiratory: ❑ Emphysema ❑ Bronchitis ❑ Asthma ❑ TB (❑ present ❑ past) ❑ Persistent Cough ❑ COPD ❑ Sleep Apnea

GI: ❑ Polyps ❑ Reflux ❑ Abdominal Pain ❑ Ulcers ❑ Colon Cancer
❑ Crohn's ❑ Colitis ❑ Blood in stools ❑ Hepatitis/other liver disease:

Neuro: ❑ Seizures ❑ Migraine ❑ Stroke: Residual Deficits:
❑ Other Neuromuscular disease:

Other: ❑ Diabetes ❑ Prostate Problems ❑ Kidney Disease ❑ Renal Failure/Dialysis ❑ Arthritis/Joint Pain
❑ Bladder Problems ❑ Weight loss ❑ Vision Problems ❑ Hearing Problems ❑ Fever
❑ Cancer: ❑ Anticoagulant use (❑ Aspirin ❑ Plavix ❑ Coumadin ❑ Other: _____)

If female, are you or could you be pregnant? ❑ Yes ❑ No
Last menstrual period

Do You Smoke? ❑ NO ❑ YES How much ❑ Quit
Do You Drink Alcohol? ❑ NO ❑ YES How much ❑ Quit

WHAT SURGERIES HAVE YOU HAD?

1.	4.
2.	5.
3.	6.

BELONGINGS: Do You Have . . .
GLASSES/CONTACTS: ❑ YES ❑ NO ❑ Body Piercing: _____
DENTURES: ❑ YES ❑ NO _____
HEARING AID: ❑ YES ❑ NO

List any other item(s) you must keep with you, such as a cane, brace, or walker _____

FAMILY HISTORY: ❑ Cancer; What kind?
Do You . . . ❑ Live Alone ❑ Live with Family ❑ Live at Nursing Home ❑ Receiving Home Health Visits

NOTES:

PAIN: Using the following scale, please rate the pain you have at this time.
❑ (0) None
❑ (1) Minor, annoying, does not interfere with normal activiities
❑ (2) Considerable intermittent pain that may sometimes disrupt my ability to function
❑ (3) Severe pain that incapacitates my ability to do anything.

I hereby verify the above information to be true and correct:

SIGNATURE: _____
RELATIONSHIP IF OTHER THAN PATIENT

_____
COMPLETED/REVIEWED BY R.N. DATE

PATIENT IDENTIFICATION: