The Endoscopy Center at Bainbridge, LLC

8185 East Washington St., Bainbridge OH 44023 (440)708-0582

PATIENT QUESTIONAIRE

COMPLETE AND BE PREPARED TO REVIEW THIS FORM THE DAY PRIOR TO YOUR PROCEDURE.

A NURSE WILL CALL BETWEEN NOON AND 330PM WITH YOUR PROCEDURE TIME.

BRING THIS COMPLETED FORM WITH YOU THE DAY OF YOUR PROCEDURE.

*****PLEASE LEAVE ALL JEWELRY AND VALUABLES AT HOME *****

NAME: **PHYSICIAN:**

Procedure: ☐ EGD ☐ Dilation ☐ Colonoscopy ☐ EGD/Colonoscopy ☐ Push Enteroscopy

Reason for the Procedure: _____

Prior Endoscopy Experience: ☐ Yes ☐ No Where/When? _____

Prep Type: ☐ Golyte/Colyte ☐ Pills ☐ Fleets Phospha Soda ☐ OTHER

HEIGHT: _____ WEIGHT:_____

Escort/Driver Name _____ Escort/Driver Phone Number _____

May we speak with your escort regarding the results of your exam? ☐Yes ☐No

ALLERGIES: ☐ No ☐ Yes Substance/Reaction_____

LATEX ALLERGY: ☐ No ☐ Yes

CURRENT MEDICATIONS

Medication	Dose	Last Date Taken

MEDICAL HISTORY

Cardiovascular? ☐ NO ☐ YES, *please check all that apply*

☐ Abnormal heart rhythm ☐ Cardiomyopathy ☐ Chest pain ☐ CHF ☐ Coronary artery disease ☐ High cholesterol

☐ High blood pressure ☐ Heart attack (MI)-DATE _____ ☐ Peripheral edema ☐ Valvular disease

☐ OTHER

Implanted cardiac device?

☐ Defibrillator ☐ Pacemaker ☐ Stent ☐ Value replacement

Pulmonary? ☐ NO ☐ YES, *please check all that apply*

☐ Asthma ☐ Bronchitis ☐ COPD ☐ Emphysema ☐ Pneumonia ☐ Productive cough ☐ Recent respiratory infection

☐ Sleep apnea ☐ Dyspnea ☐ Tuberculosis ☐ USES CPAP ☐ Other _____

Do you have Digestive or Intestinal problems? ☐ **NO** ☐ **YES,** *please check all that apply*

☐ Anemia ☐ Constipation ☐ Crohn's Disease ☐ Diarrhea ☐ Family history of colon cancer- Who/age? _____

☐ Family history of polyps ☐ Gastric reflex ☐ Hepatitis ☐ Hemorrhoids ☐ Hiatal hernia ☐ IBS

☐ Personal history colon polyps ☐ Rectal bleeding ☐ Swallowing ☐ Ulcers ☐ Unexplained weight loss

☐ Other

Are you a Diabetic? ☐ No ☐ Yes *If yes, treated with* ☐ Diet ☐ Insulin ☐ Oral Medication

Do you have Renal or Endocrine issues? ☐ No ☐ Yes

☐ Dialysis ☐ Kidney stones ☐ Renal insufficiency ☐ Hyperthyroidism ☐ Hypothyroidism ☐ OTHER

Do you have any Neurological Problems or Musculoskeletal History? ☐ No ☐ Yes

☐ Accident/Injury ☐ Amputation ☐ Arthritis ☐ Headaches ☐ Limited ROM ☐ Migraines ☐ MS ☐ Neck/Back Pain

☐ Paralysis ☐ Prosthesis ☐ Seizure disorder ☐ TIA / CVA ☐ OTHER

Have you ever had Cancer? ☐ No ☐ YES Where _____ When _____

Treatment modality ☐ Chemotherapy ☐ Surgery ☐ Radiation Therapy

Other health issues we should be aware of?

SURGICAL HISTORY

Have you had previous surgeries? Please check all that apply.

☐ Appendectomy ☐ Bowel resection ☐ CABG ☐ Cholecystectomy ☐ Colectomy-TOTAL ☐ Gastrectomy

☐ Hemicolectomy-LEFT ☐ Hemicolectomy-RIGHT ☐ Hernia repair ☐ Hysterectomy ☐ Joint replacement

☐ Total hip-LEFT ☐ Total knee-LEFT ☐ Mastectomy-LEFT ☐ Mastectomy-RIGHT ☐ Nissen fundoplication

☐ Total hip-RIGHT ☐ Total knee-RIGHT ☐ Tubal ligation ☐ Valve replacement

☐ OTHER

History of problems with anesthesia? ☐ No ☐ Yes

☐ Allergic reaction ☐ Fainted ☐ Hyperexcitability ☐ Hyperthermia ☐ Decreased blood pressure ☐ Persistent nausea

☐ Persistent vomiting ☐ Prolonged sedation ☐ Increased heart rate ☐ Unstable blood pressure

☐ Other

Do you have removable dental work? ☐ NO ☐ YES

☐ Dentures ☐ Dentures partial-UPPER ☐ Dentures partial-LOWER ☐ Permanent bridge-UPPER

☐ Permanent bridge-LOWER ☐ OTHER

SOCIAL HISTORY

Do you use Tobacco? ☐ NO ☐ YES ☐ Smoke ☐ Smokeless ☐ # of packs/day

Do you drink alcohol? ☐ NO ☐ YES ☐ 1-2 drinks ☐ 3-4 drinks ☐ 5-6 drinks

PER ☐ Day ☐ Week ☐ Month

Do you use recreational drugs? ☐ No ☐ Yes

Pregnancy status: ☐ N/A ☐ Pregnant ☐ Denies pregnancy Last menstrual period? _____