55-1047 (rev 10/09)

I. Physician/Office Nurse Please complete this section.

Patient:_____ Physician:_____

Date of Procedure:_____

Check which procedure is scheduled:

□ Endoscopy □ Colonoscopy □ Flexible Sigmoidoscopy □ ERCP □ Other_____

II. Patient: Please complete numbers 1 through 17 and bring with you.

Any questions or concerns, please contact Digestive Disease Center at (410) 337-1537 between 10:00AM and 3:00PM.

1. Why are you having the procedure? What symptoms are you experiencing?_____
   _____
2. Name of the person driving you home:_____
   Will this person need to be called:_____ Phone Number:_____
3. Height:_____ Weight:_____
4. If diabetic, this mornings glucose check:_____
5. List all allergies to medications/foods/other and describe the reaction you have.

Allergy	Reaction

6. List all medications (prescribed and over the counter)

Name	Dose	Frequency	Time/Date Last Dose

If you take Aspirin, Blood Thinners or Insulin, **Please Notify Your Doctor As Soon As You Receive This Form.**

7. Medication taken for prep:_____
8. Do you usually receive antibiotics prior to tests or dental work? □ Yes □ No
   If Yes, why?_____
   If your answer is yes, please notify your doctor prior to procedure.

St. Joseph Medical Center
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Outpatient Questionnaire

Patient Identification

9. Do you have any type of visual or hearing impairment? ☐ Yes ☐ No

   If Yes, explain:_____

10. Do you wear dentures? ☐ Yes ☐ No

11. Medical Problems – Please check appropriate answer(s)

Heart Murmur	☐	Bleeding Disorder	☐	Esophageal Stricture	☐
Mitral Valve Prolapse	☐	Epilepsy	☐	Hiatal Hernia	☐
Endocarditis	☐	Arthritis	☐	Ulcer	☐
Heart Disease	☐	Gallbladder Problems	☐	Gastric Polyps	☐
Pacemaker	☐	Kidney Problems	☐	Colon Polyps	☐
Stroke/TIA	☐	Liver Problems	☐	Diverticulosis	☐
Hypertension	☐	Glaucoma	☐	Ulcerative Colitis	☐
Breathing Problem	☐	Thyroid Problems	☐	Crohn's Disease	☐
Diabetes	☐	G. I. Disorders	☐	Irritable Bowel (Spastic Colon)	☐
Cancer	☐	Esophagitis	☐	Ostomy	☐

12. List Major Surgeries and year they occurred:

_____

_____

_____

_____

_____

13. Last time you ate solid foods: Date:_____ Time:_____

14. Last time you had liquids (including sips in A.M. with medications) Date:_____ Time:_____

15. Do you use alcohol, tobacco, narcotics or barbiturates? ☐ Yes ☐ No

    Comments:_____

16. Have you had any problems with intravenous sedation? ☐ Yes ☐ No

    Comments:_____

17. Have you had an Endoscopy or Colonoscopy? ☐ Yes ☐ No Year:_____

_____

_____

Patient Identification