EASTSIDE ENDOSCOPY CENTER
Eastside Associates, L.L.C.

PATIENT QUESTIONNAIRE

Name								**Date**	
Age		**Weight**		**Height**		**Family Doctor**		**Referring Doctor**	
List all allergies to medicine	☐ None								

List all medications you take on a regular basis, including DOSE / FREQUENCY / LAST TIME TAKEN. If additional space is needed please use a separate sheet of paper.

Name		**mg Dose**		**How Often Taken**		**Last Taken**	
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	YES	NO		YES	NO
Do you have dentures, partials, loose or chipped teeth?			Have you ever had anemia?		
Do you smoke? Packs per day? _____			Do you have bleeding tendencies? If yes, what type? _____		
Have you had this procedure done before? If yes, where was it performed? _____ When? _____ What did they find? _____			Do you have any bowel problems such as colitis, polyps, cancer or diverticulosis?		
Have you ever had a problem with an anesthetic?			Have you had colon cancer or polyps? When? _____ Has anybody in your family had colon cancer or polyps? Who? _____ When? _____		
Have you ever had a heart attack?					
Do you have a heart murmur?			Have you ever been diagnosed as having any kind of cancer? Type: _____		
Have you ever had angina or pain in the chest related to your heart?					
Have you had bypass surgery?			Have you ever had any abdominal surgery? Please specify: _____		
Do you have an artificial heart valve?			Have you ever had a communicable disease? Please list: _____		
Do you have a pacemaker or defibrillator?					
Have you ever had high blood pressure?			Have you ever had a stroke?		
Have you had any difficulties with breathing or respiratory problems? (Bronchitis, asthma, emphysema?) Do you have emphysema?			Have you ever had epilepsy or seizures?		
			Have you ever had hepatitis?		
Do you have sleep apnea? If yes, how is it treated? _____			Do you have any liver problems? Please specify: _____		
Have you ever had kidney problems? Please specify: _____			Are you taking any one of the following medications? Insulin		
Do you have diabetes?			Blood thinners (coumadin, plavix)		
If yes, do you take insulin?			Tranquilizers or sedatives		
Ladies, could you be pregnant?			Antidepressants		

PLEASE ANSWER DAY OF PROCEDURE

Name of person driving you home today:					
If you are having a colonoscopy, did you finish taking the preparation to clean out your colon?	☐ Yes	☐ No	**Have you had anything to eat or drink since midnight?**	☐ Yes	☐ No