Rochester General Hospital

GASTROENTEROLOGY HEALTH QUESTIONNAIRE

Patient Label

PLEASE COMPLETE THIS FORM IN PEN AND BRING IT WITH YOU ON THE DAY OF YOUR PROCEDURE.

1. Name:________________________ Birthdate:____________

2. **IF YOU ARE BEING SEDATED, YOU MUST HAVE A RESPONSIBLE ADULT TO DRIVE YOU HOME**

Driver's Name:________________________

- ☐ In waiting room
- ☐ Please call driver - phone number:____________________
- ☐ Driver will return at (time):____________

3. Do you speak and/or understand English? ☐ Yes ☐ No

If you do not speak English, you are welcome to bring someone to help you or let us know in advance so we can make arrangements for an interpreter.

4. What medical problems/symptoms are you having that require you to have this procedure?

____________________, or is this a colon screening? ☐ Yes ☐ No

5. Is there a history of colon cancer in your family? ☐ Yes ☐ No If Yes, what is their relationship to you? ____________

6. Please check the following that apply to you (the patient):

- ☐ Cancer ____________
- ☐ Diabetes
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Seizures
- ☐ Kidney Disease
- ☐ Dialysis shunt, mediport
- ☐ Glaucoma
- ☐ Asthma, emphysema
- ☐ Sleep apnea
- ☐ Joint replacements/prosthesis
- ☐ Arthritis
- ☐ Blood clots
- ☐ Heart attack, angina
- ☐ Irregular heart beat
- ☐ Heart Valve Replacements
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Anemia
- ☐ Ileostomy
- ☐ Colostomy
- ☐ History of colon polyps
- ☐ Colitis, Crohn's disease
- ☐ Irritable bowel syndrome
- ☐ Diverticulosis/Diverticulitis
- ☐ Hiatal Hernia
- ☐ Gastric ulcers
- ☐ Barrett's esophagus
- ☐ Hepatitis
- ☐ Liver Cirrhosis/Jaundice
- ☐ GERD (Gastroesophageal Reflux Disease)
- ☐ Pancreatitis
- ☐ Pacemaker/Defibrillator (bring medical alert card)
- ☐ Tobacco, type____________________
- ☐ Drink alcohol, frequency ____________________
- ☐ Recreational drugs, name ____________________
- ☐ Are you pregnant? ☐ Yes ☐ No ☐ N/A Last menstrual period:__________
- ☐ Other:

7. List <u>all</u> surgeries you have had, and when you had them:________________________

____

____

8. **NUTRITIONAL INFORMATION:**

How much do you weigh? ____________lbs. ____________kg

Change in appetite: ☐ Yes ☐ No Change in Weight: ☐ Yes ☐ No

Lost how much ____________ over how long ____________

Gained how much ____________ over how long ____________

Reason for weight gain/loss:________________________

9. Do you have any religious, spiritual or cultural beliefs that would affect your care? ☐ Yes ☐ No

If Yes, explain:________________________

10. Do you have a history of being a victim of violence? ☐ Yes ☐ No

Would you like a referral? ________________________

For official use only: *Date* ________ *Time:* ________

Reviewed by: ________________________

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Date: ______________________

Please list medications/foods that you are allergic/sensitive to *including the reaction you have to them:*

MEDICATION ALLERGY	REACTION	FOOD OR OTHER ALLERGY	REACTION
☐ No known allergies		☐ No known allergies	

Are you allergic to Latex (rubber products)? ☐ **Yes** ☐ **No** **Reaction**:____________________________________

List current medications, over the counter medications, vitamins and/or herbal supplements you are taking. Include dose written on bottle (mg or ml) and how often you take them, or attach a copy of your medications. This includes all aspirin, anti-inflammatory medications (eg. Celebrex, Advil, Mobio, etc.), and anticoagulation medication that you have stopped for this procedure (eg. Coumadin, Heparin, Lovenox, Plavix).

MEDICATION	DOSE	FREQUENCY	DATE LAST TAKEN

. If you take anti-coagulation medication (eg. Coumadin), did you have blood drawn in preparation for this procedure?
☐ Yes ☐ No ☐ N/A

For official use only: *Date* ___________ *Time:* __________
Reviewed by: ____