SEASIDE ENDOSCOPY PAVILION
HEALTH QUESTIONNAIRE

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

NAME _____ DATE _____

TYPE OF PROCEDURE YOU ARE HAVING DONE _____

Do you have **Advance Directives**? Yes___ If yes, please bring a copy with you.
No ___Would you like information? Yes___ No___

Have you fallen in the last 3 months? No_____ Yes_____

Please check if you have or have had any of the following:					
	YES	**This column for nurse's use only**		**YES**	**This column for nurse's use only**
Diabetes			Thyroid disease		
Heart attack			Kidney disease		
Pacemaker/AICD			Liver disease		
Cardiac stents			Hepatitis/ HIV		
Atrial Fibrillation			Arthritis		
Anemia			Seizures		
High Blood Pressure			Depression/ Anxiety		
Stroke/TIA			Parkinson's		
Dizziness			GERD		
Rheumatic fever			Hiatal Hernia		
Scarlet fever			Barrett's esophagus		
Asthma			Stomach ulcers		
COPD			Colon polyps		
Recent cold/cough			Diarrhea		
TB			Constipation		
Sleep apnea			Crohn's		
Broken/loose teeth			Ulcerative colitis		
Cancer			IBS		
Do you use any of the following:			**Do you wear:**		
Tobacco			Glasses/contacts		
Alcohol			Dentures		
Recreational drugs			Hearing aids		
Females only:					
Any possibility you could be pregnant?			Are you breast feeding?		

Please list any Surgeries with the year done:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list allergies and medications on attached page.

PATIENTS MAY NOT DRIVE AFTER RECEIVING SEDATION/ANESTHESIA.

Name/phone# of person driving you home: _____

Patient's Signature _____ Date_____

SEASIDE ENDOSCOPY PAVILION MEDICATION LIST

List all allergies to **MEDICATIONS, FOODS, OTHER** and describe the reaction

Allergy/Sensitivity	Yes	No	Reaction	Medication Allergies	Reaction
Latex					
Peanuts					
Eggs					
Soy					
Other foods					

List all medications that you take: **prescribed, over the counter, including herbal medications**

If you use inhalers, please bring them with you.

Name of medication	Dose	Frequency	Last Taken	Reason for medication	Resume (for nurse's use)

Attach additional page if necessary

Nurse to complete this section post-procedure:

Medication additions or changes:

Name of medication	Dose	Frequency	Start Date	Reason for medication

Patient Signature:_____ Date:_____

Nurse's Signature:_____ Date:_____

Physician Signature:_____ Date:_____