2501 West 12th Street Erie, PA 16505
833-0071/www.svecpa.com

PATIENT QUESTIONAIRE

COMPLETE AND BE PREPARED TO REVIEW THIS FORM THE DAY PRIOR TO YOUR PROCEDURE.
A NURSE WILL CALL BETWEEN NOON AND 3:30PM WITH YOUR PROCEDURE TIME.
YOU MAY CALL IF PREFERRED
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

Reason for the Procedure: ____________________

Prior Endoscopy Experience: ❑ Yes ❑ No Where/When? ____________

Prep Type: Nulytely Pills Miralx MoviPrep Halflytely 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? *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 ❑ Valve replacement

Pulmonary? *please check all that apply*

❑ Asthma ❑ Bronchitis ❑ COPD ❑ Emphysema ❑ Pneumonia ❑ Productive cough

❑ Recent respiratory infection ❑ Sleep apnea ❑ Dyspnea ❑ Tuberculosis ❑ USES CPAP ❑ Other _____

END-16 (6/1/09)

Do you have Digestive or Intestinal problems? *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? *If yes, treated with* ❑ Diet ❑ Insulin ❑ Oral Medication

Do you have Renal or Endocrine issues? *Please check all that apply*.
❑ Dialysis ❑ Kidney stones ❑ Renal insufficiency ❑ Hyperthyroidism ❑ Hypothyroidism ❑ OTHER

Do you have any Neurological Problems or Musculoskeletal History? Please check all that apply
❑ Amputation ❑ Arthritis ❑ Headaches ❑ Limited ROM ❑ Migraines ❑ MS ❑ Neck/Back Pain
❑ Paralysis ❑ Prosthesis ❑ Seizure disorder ❑ TIA / CVA ❑ OTHER

Have you ever had Cancer? ❑ No ❑ YES Which Type of Cancer______________________ When ______
Treatment modality ❑ Chemotherapy ❑ Surgery ❑ Radiation Therapy

Bleeding Tendency ❑ No ❑ YES Please Specify_____________________________

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? ______