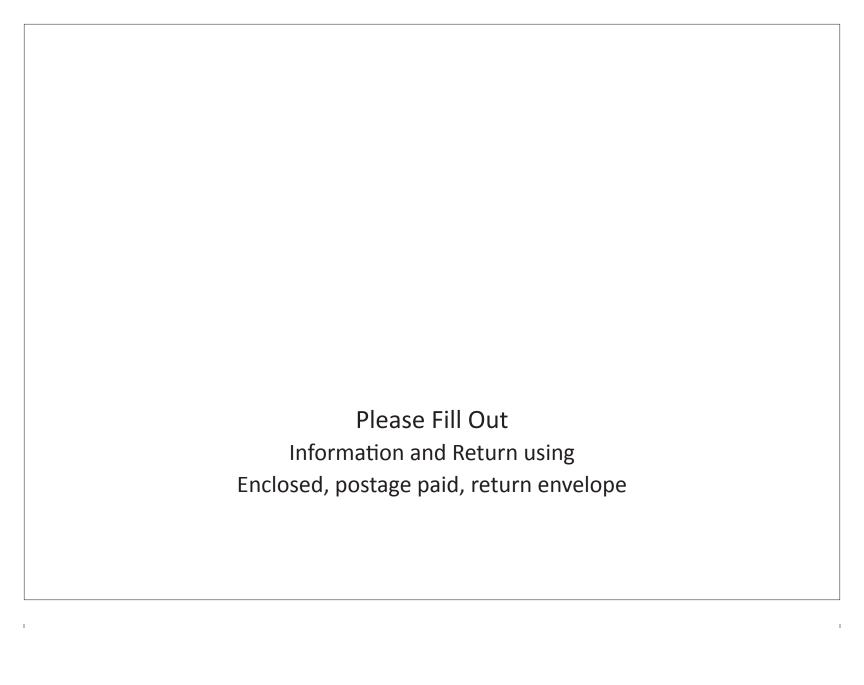
NAME AND DOB:		CHART #:	
GI SCHEDULING QUESTIONNAIRE			
Do you have a history of heart disease, live	er disease, or kidney diseas	se?	
Do you use a pacemaker, defibrillator, sup			
Have you ever had a heart attack or stent	placed? If yes	, when?	
Do you have mitral valve prolapse?			
What is your current height?			
What is your current insurance?	Policy #	Group #	
* If able, please fax an enlarged	copy of the front and back	of your card to : 919-714-6010	
Do you use a CPAP machine?	Is your sleep apnea mild, moderate, or severe?		
Have you had issues being intubated or se	edated? Have you	received an intubation letter?	
Do you take any prescribed blood thinners	s? (Plavix, Coumadin, Xarel	to, etc.)?	
* Who Prescribes this medication			
Do you take any blood pressure medication			
Do you take any aspirin, fish/krill oil, vitan	nin E, iron, or weight loss su	upplements?	
Do you take any antidepressants, anxiety	or pain meds on a daily bas	sis? Please list below:	
Are you diabetic?			
Do you have an allergic reaction to latex?	Does it caus	e breathing difficulty?	
Do you have an allergic reaction to eggs/s	oy? Does it ca	use breathing difficulty	
How often do you have a bowel movemer	nt?		
Who is your primary care?	Which	Practice?	
What pharmacy do you use?			
Best contact number?		day to contact: AM PM	
Can we contact you by email? Email:			

File Name: 100117 WIM GI Scheduling Questionaire Update GR17040

Size: 8.5" w x 6" h Color:K Sales Rep: Connor Allegood

Modified Date: October 25, 2018 4:34 PM



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