NAME: _____ DATE OF BIRTH: _____ CHART #:_____

PROCEDURE REQUESTED _____ DIAGNOSIS_____

PRIMARY CARE PROVIDER _____

GI Scheduling Questionnaire

Do you have history of heart, kidney, or liver disease? If yes, what? _____

Do you use any cardiac devices, supplemental oxygen, or are you currently on dialysis? _____

Any history of stroke, seizure, pulmonary embolism, or deep vein thrombosis? If yes, when? _____

Any history of heart attack, stent placement, or valve replacement? If yes, what and when? _____

Are you seeing any specialists? What doctor and location? _____

Date of last appointment with specialist? _____ Do you have any pending testing? _____

What is your current height? _____ Current weight? _____

Do you use a CPAP? _____ If yes, do you know the current pressure setting? _____

Are you taking blood thinning medications? What? _____ Who prescribes? _____

Do you take any aspirin, fish oil, vitamin E, iron, or weight loss medications? _____

_____

Do you take any diabetic, blood pressure, antidepressant, anxiety, or pain medications? Please circle and list.

_____

Do you take Celebrex, Meloxicam, or any generic forms of these medications? _____

Have you ever had an allergic reaction to latex? _____ Does exposure cause breathing issues or cough? _____

How often are you having a bowel movement? _____ Are you using laxatives or fiber supplements? _____

What pharmacy would you like prescriptions sent to? _____

What is your contact information? Email _____

Phone Number _____ Best time to call? _____