CENTRAL JERSEY GASTROENTEROLOGY ASSOCIATES, P.A.

PRE-ADMISSION PATIENT QUESTIONNAIRE

INSTRUCTIONS: Please fill in all areas of this form prior to your arrival. Bring the completed form with you on the day of your procedure and give it to the receptionist at check-in.

Name:

Date of Birth

Height: Feet Inches:

Weight: Lbs:

Driver's Name:

Driver's phone: Cell

Home

Do you smoke ☐ No ☐ Quit ☐ Yes

If yes: No. of yrs

No of packs per day

List Previous Surgeries and Years

History of patient or family problems with anesthesia

◯ No ◯ Yes

Explain if yes

Food &/or Medication Allergies

◯ No ◯ Yes

List if yes:

Latex Allergy:

- ◯ No
- ◯ Yes (explain)
- ◯ To bandaids
- ◯ To elastic

Explain

Past Medical History check all that apply:

- ☐ Bleeding Tendency
- ☐ Heart attack/cardiac stents
- ☐ Heart disease, irregular beats
- ☐ Heart murmur, mitral valve prolapse
- ☐ Cancer (describe below)

Cancer - Please explain:

Lung problems:

- ☐ asthma
- ☐ bronchitis
- ☐ emphysema
- ☐ COPD
- ☐ Tuberculosis

- ☐ Diabetes
- ☐ Glaucoma
- ☐ macular degeneration

GI problems

- ☐ Barrett's
- ☐ diverticulosis
- ☐ diverticulitis
- ☐ polyps
- ☐ colitis
- ☐ IBS
- ☐ Crohn's Disease
- ☐ GERD/reflux
- ☐ hiatus hernia
- ☐ Liver disease
- ☐ cirrhosis

- ☐ Migraine headaches
- ☐ HIV
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ Implants (orthopedic)
- ☐ Immune disease

Please explain Immune disease

- ☐ Menopause

Neurological problem:

- ☐ TIA
- ☐ CVA/stroke
- ☐ Parkinsons

Last Menstrual Period (approx date)

- [ ] Pacemaker
- [ ] Psychiatric illness
- [ ] Rectal bleeding
- [ ] Prostate or bladder problems
- [ ] Kidney disease
- [ ] Seizures
- [ ] Sleep apnea
- [ ] Thyroid disease
- [ ] Victim of abuse
- [ ] Neck problems
- [ ] Spine problems
- [ ] Back problems

Complete the list of medications on the next page.

Medications: list below all prescription medications, vitamins, and over-the-counter medications, and natural supplements

Name/dose of medication	Frequency	Last dose