DHA Endoscopy LLC
91 Montvale Ave. Suite # 103
Stoneham, MA 02180
781-835-2111
DHAENDOSCOPY.COM

Patient Name_____

Date of Birth _____

PRE-ADMISSION QUESTIONNAIRE

Primary Care Physician_____ Endoscopist_____

Procedure_____ Reason for Procedure_____

May we leave medical information on an answering machine or voicemail? Yes No
May we discuss procedure results with anyone other than you? Yes No Who?_____
Do you have an advance directive (Health Care Proxy)? Yes No Who?_____
If No, would you like any additional information Yes No ?

Name and telephone number of person who will be driving you home after the procedure:

Name_____ Telephone #_____

PLEASE ANSWER THE FOLLOWING ABOUT YOUR PERSONAL HISTORY:

Yes	No		Explanation if yes
___	___	Heart disease/Murmur/Valve disease	_____
___	___	High Blood Pressure	_____
___	___	Breathing/Lung problems	_____
___	___	Seizures/Stroke/Epilepsy	_____
___	___	Liver or Kidney disease	_____
___	___	Diabetes	_____
___	___	Arthritis/Limitations of movement	_____
___	___	Bleeding problems/Blood thinners	_____
___	___	Problems with anesthesia or sedation	_____
___	___	Recreational drug use?	_____
___	___	Are you pregnant or nursing?	_____
___	___	Pregnancy test taken?	_____
___	___	Pregnancy test waiver signed (if applicable)?	_____

Do you drink Alcohol ? How much? _____

Do you Smoke ?How much?How long?_____

Any other medical problems not listed above? List Surgical operations _____

_____

_____

_____

Please turn over page to finish questionnaire on opposite side

Are you Allergic or sensitive to medications? ___Yes ___None known If Yes, list medication(s) and type of reaction _____

Are you Allergic or sensitive to other materials? ___Yes ___None known If Yes, list material(s) (latex, iodine etc) and type of reaction _____

Do you wear Dentures or have a removable bridge? ___Yes ___No

When did you last eat? Food?_____ Liquid? _____

Additional information you would like to give to your doctor about this procedure: _____

_____

PLEASE ALSO FILL OUT THE MEDICATION FORM PRIOR TO YOUR VISIT

If you receive sedation, you may not operate a motor vehicle, mechanical/electrical equipment or make any critical decisions until the next day after your procedure. Doing any such activities could lead to injury of yourself and/or others.

X _____

Patient/Authorized Representative Signature

Please do not write below this line - for physician use only

Physician's Pre-procedure History and Physical – to be completed in the pre-procedure area

Medical History- Reviewed ___yes Notes:_____

_____

Current Medications Reviewed ___yes Notes:_____

Allergies Reviewed ___yes Notes:_____

Pre-procedure Physical Exam

Airway: Normal Dental Abnormalities Mandibular Abnormalities Partial Airway Obstruction Other:

Lungs: Clear Consolidation Wheezes Decreased Excursion Crackles Other:

Heart: Normal Irregular Rhythm Murmur Gallop Click Other

Neuro: Normal Confused Vague Decreased Consciousness Focal deficit:

Mallampati score: 1 2 3 4

ASA Classification: Class 1 Class 2 Class 3

I have personally reviewed the above patient's medical history, current medications, allergies, NPO status, and planned procedure and have performed a physical exam. I certify that based on this information that the patient is an appropriate candidate for an outpatient ambulatory endoscopy procedure

_____

M.D. Signature Date Time