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*Gastroenterology
Hepatology
Diagnostic Endoscopy
Therapeutic Endoscopy
Endoscopic Ultrasound
G.I. Motility
Endoscopic Oncology*

SCREENING/ON-DEMAND ENDOSCOPY QUESTIONNAIRE

NAME: _____ **DOB:** _____

HEART DISEASE/ATTACK/SURGERY _____ **YES** **No**

HEART MURMUR _____ **YES** **No**

PACEMAKER OR DEFIBRILLATOR _____ **YES** **No**

RHEUMATIC FEVER _____ **YES** **No**

LUNG DISEASE _____ **YES** **No**

STROKE _____ **YES** **No**

SEIZURES _____ **YES** **No**

DIABETES _____ **YES** **No**

BLEEDING DISORDERS _____ **YES** **No**

ARTIFICIAL VALVE _____ **YES** **No**

JOINT REPLACEMENT _____ **YES** **No**

OTHER ILLNESSES/DISEASES _____ **YES** **No**

TAKE ASA/NSAIDS _____ **YES** **No**

ALLERGIES TO MEDICINES _____ **YES** **No**

SURGERIES _____ **YES** **No**

CURRENT MEDICATIONS: _____
