NORTHEAST ENDOSCOPY L.L.C.
59 LOWES WAY • LOWELL, MA 01851
TEL: 978-349-2146 • FAX: 978-349-2151

Name_____

PRE-ADMISSION QUESTIONNAIRE

PRIMARY CARE PHYSICIAN _____ ENDOSCOPIST _____

PROCEDURE: _____ REASON FOR PROCEDURE: _____

MAY WE LEAVE A FOLLOW UP MESSAGE ON AN ANSWERING MACHINE/VOICEMAIL? YES NO

MAY WE DISCUSS YOUR PROCEDURE WITH ANYONE OTHER THAN YOU? _____

**** PLEASE BRING THIS FORM, YOUR INSURANCE CARD(S) AND BE CERTAIN TO LIST *ALL OF YOUR MEDICATIONS*.**

**** YOU MUST HAVE A RIDE HOME *WITH* A RESPONSIBLE ADULT; A TAXI WITH A RESPONSIBLE ADULT (NOT THE TAXI DRIVER) IS ALLOWED.**

**** YOUR RIDE *MUST* ACCOMPANY YOU OR BE AVAILABLE BY PHONE AT TIME OF CHECK IN.**

**** PLEASE DO NOT WEAR ANY BODY LOTIONS OR OILS ON THE DAY OF YOUR PROCEDURE.**

WE MUST HAVE THE NAME *AND* TELEPHONE NUMBER OF THE PERSON WHO WILL BE DRIVING YOU HOME AFTER THE PROCEDURE:

NAME: _____ **TELEPHONE #** _____

PLEASE MARK THE FOLLOWING APPROPRIATELY:

YES	NO	PERSONAL HISTORY (SELF)	EXPLANATION, IF YES
_____	_____	HEART DISEASE	_____
_____	_____	HIGH BLOOD PRESSURE	_____
_____	_____	BREATHING/LUNG PROBLEMS	_____
_____	_____	SEIZURES/STROKES/EPILEPSY	_____
_____	_____	LIVER/KIDNEY DISEASE	_____
_____	_____	HISTORY OF CANCER (SELF)	_____
_____	_____	DIABETES	_____
_____	_____	THYROID PROBLEMS	_____
_____	_____	ARTHRITIS/LIMITATIONS OF MOVEMENT	_____
_____	_____	DIARRHEA/CONSTIPATION	_____
_____	_____	TROUBLE SWALLOWING/FOOD STICKING	_____
_____	_____	SMOKE -- IF YES, AMOUNT	_____
_____	_____	DRINK ALCOHOL -- IF YES, AMOUNT	_____
_____	_____	PREGNANT	_____

-OVER-