Maryland Endoscopy Center, L.L.C.
100 West Road - Suite 115
Towson, Maryland 21204

**** PLEASE BRING THIS COMPLETED FORM TO YOUR PROCEDURE***

PATIENT QUESTIONNAIRE

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Last Name **First** **Middle Initial**

*****IF YOU TAKE BLOOD THINNERS OR INSULIN, IF YOU HAVE AN INTERNAL DEFIBRILLATOR, OR IF YOU WILL NEED AN INTERPRETER, PLEASE NOTIFY YOUR DOCTOR PRIOR TO THE PROCEDURE.**

*****For your safety, please contact your doctor if your weight is greater than 300 pounds.**

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PATIENT - Please complete numbers 1 to 13 (Front and Back)

Any questions or concerns, please contact Maryland Endoscopy Center at **410-494-0144 between 7:30am and 3:00pm.**
Visit our web site at www.marylandendoscopycenter.com **Fax number: 410-494-0147**

1. Why are you having the procedure? What symptoms are you experiencing? ____________________________
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2.Primary Care Provider ______________________________________

3. Name of person driving you home ______________________ Relationship: Spouse Other Family Friend
May they hear the results of your procedure? YES NO Phone Number ______________________

4. Check if you have ever had any of the following:

___Sleep Apnea
___Thyroid Problems
___Irregular Heart Rate
___Heart Murmur
___Mitral Valve Prolapse
___Heart Attack
___High Blood Pressure
___Endocarditis
___Stroke/TIA
___Neurological Condition____________
    ___Parkinson's Disease
___Diabetes
___Bleeding Disorders
___Epilepsy
___Arthritis
___Kidney Problems
___Liver Problems (Hepatitis)
___HIV
___Glaucoma
___Breathing Problems
    ___COPD
    ___Asthma
    ___Emphysema

___Reflux Esophagitis
___Esophageal Stricture
___Barrett's Esophagus
___Hiatal Hernia
___Ulcers
___Polyps of the stomach
___Elevated Cholesterol
___Colon Polyps
___Diverticulosis/Diverticulitis
___Crohn's Disease
___Ulcerative Colitis
___Irritable Bowel / Spastic Colon
___Ostomy
___Hemorrhoids
___Family History of Colon Cancer ______________
___Family History of Polyps__________________
___Personal History of Colon Cancer
___Other________________________________

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5. List ***SURGERIES*** and the ***YEARS*** in which you had these done. Please include if any ***metal*** remains in the body.

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6. **Date of Last Colonoscopy:**______________________________

7. Do you normally receive antibiotics prior to tests or dental work?
_____ No _____ Yes Why? ____

8. For Women: Are you pregnant? ____No ____Yes Date of last menstrual period: ________________________

9. Do you have any hearing, visual or physical impairment?
____No ____Yes Explain____

10. Have you had any problems with intravenous sedation or anesthesia?
___Yes ___No Describe____

11. Check if you use any of the following:
Alcohol ___Yes ___No Quantity per day____
Tobacco ___Yes ___No Quantity per day____
Narcotics ___Yes ___No Quantity per day____

12. We will call to check up on you the next business day after your procedure. If you are not at home, can we leave a message on your answering machine or speak with whomever answers your phone? ___Yes ___No. If not, what is an alternate phone number where you may be reached? ______________________________

13. Do you have Advance Directives, i.e., Living Will, etc., in place now? ___Yes ___No
If you checked yes, please bring a copy with you on the day of your procedure.

Reviewing RN
signature____Date/Time__________________________

Revised: 4/16