Hartford Hospital GI Endoscopy Unit
PATIENT PRE-ADMISSION QUESTIONNAIRE

Name _____ **Phone #** _____
D.O.B._____ **Height** _____ **Weight** _____ **Procedure Date** _____
What procedure are you having: ☐ Colonoscopy ☐ Endoscopy ☐ Endoscopic Ultrasound ☐ Motility ☐ Other
Reason for procedure _____
PCP Name _____ **Phone #** _____
Cardiologist Name _____ **Phone #** _____
Family history of colon/esophageal/gastric cancer? ☐ Yes ☐ No **If yes, who**: _____

Personal Medical History

Medication allergies: _____ Reaction_____

Latex Sensitivity	☐ Yes	☐ No	Pregnant	☐ Yes	☐ No
Heart Problem	☐ Yes	☐ No	Breast Feeding	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Smoker	☐ Yes	☐ No
Valve replacement	☐ Yes	☐ No	Breathing problems	☐ Yes	☐ No
Pacemaker/AICD	☐ Yes	☐ No	if Yes, explain:_____		
Stroke	☐ Yes	☐ No	Sleep Apnea:	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Alcohol Use:	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No	Cancer:	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	if Yes, type:_____		
Liver problems	☐ Yes	☐ No	Other medical conditions:_____		

Have you had sedation in the past ☐ Yes ☐ No _____
Have you had a bad reaction to sedation ☐ Yes ☐ No _____
if Yes, please describe:_____
Surgeries:_____

List Medications: (include prescription and over the counter medications)

Medication name: copy name on medicine bottle	Dosage

***Aspirin, Ibuprofen, Nsaids, Plavix, and Coumadin may need to be stopped before your procedure. Follow your doctor's orders as to when you should stop these medications and any other over the counter supplements (multivitamins, herbal supplements, glucosamine etc.).**

Please mail at least 2 weeks before exam to:
Hartford Hospital
85 Jefferson Street
Hartford, CT 06102
(860) 545-2111

OR

FAX to:
(860) 545-2785