

**ENDOSCOPY PRE-ANESTHESIA QUESTIONNAIRE**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

PROCEDURE (circle) GASTROSCOPY COLONOSCOPY BRAVO

AGE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

ALLERGIES (circle) NO YES (list all drug, food and environmental allergies) \_\_\_\_\_

ANESTHESIA have you or an immediate family member had problems with anesthesia? (circle)  
NO YES (describe) \_\_\_\_\_

PAST SURGERIES \_\_\_\_\_

MEDICATIONS (include medications you may have stopped for this procedure)

		Plavix no / yes: date of last dose
		Aspirin no / yes: date of last dose

**MEDICAL HISTORY (circle)**

CVS: high blood pressure angina heart attack (when)  
angioplasty stents heart failure  
irregular heart beat syncope heart valve problems  
stress test (when) catheterization (when) echocardiogram (when)  
pacemaker defibrillator

RESP: asthma emphysema/COPD sleep apnea

CNS: stroke TIA seizures

GI: reflux hiatal hernia gastroparesis

DIABETES THYROID KIDNEY LIVER BLOOD DISORDER CANCER

OTHER \_\_\_\_\_

SMOKING (circle) NO YES ALCOHOL (circle) NO YES

TEETH (circle) dentures loose teeth caps/laminates bonded front teeth

CONTACT LENSES are you currently wearing them? (circle) NO YES