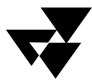


EXETER HOSPITAL
5 Alumni Drive Exeter, NH 03833 603.778.7311

PATIENT ID OR LABEL

GI ENDOSCOPY
HEALTH QUESTIONNAIRE / ASSESSMENT

Office Use Only: New or Est. Patient   Colon or EGD

Dr. ______________________ Date:__________________

Prep: ☐ Miralax ☐ Fleets ☐ Nulytely ☐ Golytely

Please complete the following questions to the best of your ability. The information will be reviewed and will assist in preparation of your procedure.

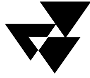
Patient Questions		Individual Care Plan For Nurses' Use Only
Patient Name: ______________________ Date of Birth: ____________		**Language Barrier:** ☐No ☐Yes Needs:________________
• What is your primary language? ☐ English ☐ Other________________________		
• What is your primary place of residence? ☐ With family ☐ Alone ☐ Other________________________		
Occupation: ______________________		
Reason for Procedure: ☐ Screening ☐ Other:		
• Will this procedure interfere with any of your cultural / religious practices? If yes, explain:______________________	☐No ☐Yes	
• Are your childhood immunizations complete? (18 years or younger)	☐No ☐Yes	Type:________________
• Do you have an Advance Directive for Healthcare or Living Will? If yes, please bring a copy with you the day of your procedure.	☐No ☐Yes	Would you like information? ☐Yes ☐No
• Do you have any recent life stress or concerns?	☐No ☐Yes	
• Have you had any recent weight changes? If yes, ☐Gain ☐Loss Amount:________________	☐No ☐Yes	
• Have you or any of your family had past problems with anesthesia or sedation?	☐No ☐Yes	Type:________________
• Do you have any allergies to medications? If yes, list:______________________ Type of Reaction(s):______________________	☐No ☐Yes	☐ ADS Reviewed
• Latex Allergy?	☐No ☐Yes	

Health Survey: Do you have any problems with any of the following: (Please check all appropriate conditions)

☐High Blood Pressure	☐Seizure Disorder	☐Diabetes	☐Hepatitis
☐Cancer	☐Tuberculosis	☐Chest Pain	☐Heart Murmur
☐Thyroid Problems	☐Liver Disease	☐Bleeding / Bruising	☐Bowel Problems
☐Sleep Apnea	☐GERD (heartburn)	☐Immune Disorders	☐Arthritis
☐Anxiety / Depression	☐Arrhythmia	☐Glaucoma	☐Heart Disease
☐Respiratory Problems	☐Osteoporosis	☐High Cholesterol	☐Kidney Disease
☐Asthma	☐Anemia		

Medication History (Including prescription, over-the counter, vitamins and herbals – including herbal teas):

Medication	Dose & Frequency	Last Dose Taken (Date / Time)



EXETER HOSPITAL
5 Alumni Drive Exeter, NH 03833 603.778.7311

Patient Name: ___________________________
Date of Birth:____________________________

GI ENDOSCOPY
HEALTH QUESTIONNAIRE / ASSESSMENT

Question		For Nurses' Use Only
• Other health problems:		
• Do you have a family history of colon cancer / colon polyps? If yes, whom:____	☐No ☐Yes	
• Women – Could you be pregnant? LMP____	☐No ☐Yes	
• Do you take Aspirin on a regular basis?	☐No ☐Yes	Date last taken: __________
• Do you take anti-inflammatory medications? If yes, what type? (e.g., Advil, Nuprin, Relafen):____________________	☐No ☐Yes	Date last taken: __________
• Do you take any blood thinners? If yes, what type? (e.g., Coumadin, Lovenox, Plavix):______________	☐No ☐Yes	Date last taken: __________
• Do you smoke or did you ever smoke? ___________ Packs/day Quit __________years ago	☐No ☐Yes	
• Do you drink alcohol? How much_____________________________ Quit ________years ago	☐No ☐Yes	
• Do you use recreational drugs? If yes, what type:____	☐No ☐Yes	
• Do you have any artificial joints, rods, pins, screws, etc? If yes, location:____	☐No ☐Yes	
• Do you have an artificial heart valve?	☐No ☐Yes	
• Do you have a pacemaker or AICD? If yes, for how long:____	☐No ☐Yes	
• Do you have any dietary restrictions? If yes, list____	☐No ☐Yes	
• Do you use any medical home services?	☐No ☐Yes	
• Do you use any devices to assist you in caring for yourself?	☐No ☐Yes	
• Will you need any help after your procedure?	☐No ☐Yes	
Please List Past Surgeries		

______________ Date / Time ______________________________ Patient Signature

______________ Date / Time ______________________________ Reviewed by:

☐ Reviewed by Admitting RN ☐ Reviewed by Procedure RN