

DHA Endoscopy Center, LLC
91 Montvale Ave. Suite # 103
Stoneham, MA 02180
781-835-2111
DHAENDOSCOPY.COM

Patient Name _____

Date of Birth _____

PRE-ADMISSION QUESTIONNAIRE

Primary Care Physician _____ Endoscopist _____

Procedure _____ Reason for Procedure _____

May we leave medical information on an answering machine or voicemail? Yes No

May we discuss procedure results with anyone other than you? Yes No Who? _____

Do you have an advance directive (Health Care Proxy)? Yes No Who? _____

Name and telephone number of person who will be driving you home after the procedure:

Name _____ Telephone # _____

PLEASE ANSWER THE FOLLOWING ABOUT YOUR PERSONAL HISTORY:

| Yes | No | Explanation if yes |
|-----|-----|--|
| ___ | ___ | Heart disease/Murmur/Valve disease _____ |
| ___ | ___ | High Blood Pressure _____ |
| ___ | ___ | Breathing/Lung problems _____ |
| ___ | ___ | Seizures/Stroke/Epilepsy _____ |
| ___ | ___ | Liver or Kidney disease _____ |
| ___ | ___ | Diabetes _____ |
| ___ | ___ | Arthritis/Limitations of movement _____ |
| ___ | ___ | Bleeding problems/Blood thinners _____ |
| ___ | ___ | Problems with anesthesia or sedation _____ |
| ___ | ___ | Is it possible you are pregnant? _____ |

Do you drink or smoke? How much? _____

Any other medical problems not listed above? _____

Surgical operations? _____

Are you allergic to medications? ___ Yes ___ None known If Yes, list medication(s) and type of reaction _____

Are you allergic to other materials? ___ Yes ___ None known If Yes, list material (latex, iodine etc) and type of reaction _____

PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS

| Medication Name | Strength | Times | Last Dose | Medication Name | Strength | Times | Last Dose |
|-----------------|----------|-------|-----------|-----------------|----------|-------|-----------|
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Do you wear Dentures or have a removable bridge? ___ Yes ___ No

When did you last eat? Food? _____ Liquid? _____

Additional information you would like to give to your doctor about this procedure: _____

If you receive sedation, you may not operate a motor vehicle, mechanical/electrical equipment or make any critical decisions until the next day after your procedure. Doing any such activities could lead to injury of yourself and/or others.

X _____
Patient/Authorized Representative Signature

Please do not write below this line - for physician use only

Physician's Preprocedure Assessment

I have personally reviewed the above patient's Pre-Admission Questionnaire for significant medical conditions, current medications, allergies, NPO status, and planned procedure. Additional relevant history/comments: _____

Focused Pre-procedure Physical Exam

Airway: Normal Dental Abnormalities Mandibular Abnormalities Partial Airway Obstruction Other:
 Lungs: Clear Consolidation Wheezes Decreased Excursion Crackles Other:
 Heart: Normal Irregular Rhythm Murmur Gallop Click Other
 Neuro: Normal Confused Vague Decreased Consciousness Focal deficit:

Mallampati score: 1 2 3 4

ASA Classification: Class 1 Class 2 Class 3 Class 4 Class 5 ASA "E" Modifier

I certify that I have performed an immediate pre-procedure assessment

M.D. Signature

Date