DHA Endoscopy 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? _____
If No, would you like any additional information Yes No ?

****Since our patients are here for elective procedures, the physicians and staff will not recognize Advance Directives and use every possible means available to them, include emergency room transfer to the hospital, to sustain life****

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**	_____
___	___	**Recreational Drug Use?**	_____
___	___	**Do you use oxygen at home? If yes, please call the office.**	
___	___	**Are you over 350 pounds? If yes, please call the office.**	

Do you drink Alcohol ? How much? _____

Do you Smoke ?How much?How long? _____

Any other medical problems not listed above? _____

_____

List Surgical operations _____

_____

(over)

Are you Allergic or sensitive to medications? ___Yes ___None known If Yes, list medication(s) and type of reaction _____

Are you Allergic or sensitive to other materials? ___Yes ___None known If Yes, list material(s) (latex, iodine etc) and type of reaction _____

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: _____

****PLEASE ALSO FILL OUT THE MEDICATION FORM PRIOR TO YOUR VISIT****

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 Pre-procedure History and Physical **– to be completed in the pre-procedure area**

Medical History- Reviewed ___yes Notes: _____

_____

Current Medications Reviewed ___yes Notes: _____

Allergies Reviewed ___ yes Notes: _____

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

I have personally reviewed the above patient's medical history, current medications, allergies, NPO status, and planned procedure and have performed a physical exam. I certify that based on this information that the patient is an appropriate candidate for an outpatient ambulatory endoscopy procedure

_____

MD SIGNATURE DATE TIME