

South Broward Endoscopy

11011 Sheridan Street, Suite 106
Cooper City, FL 33026
Tel. 954.435.0101 Fax 954.435.0125

Medical Questionnaire

Date: _____ Emergency Contact: _____ Phone # _____

Name of Person accompanying patient home: _____ Phone # _____

Will escort remain at Center? Yes No Age: _____ Height: _____ Weight: _____

Primary M.D.: _____ Surgeon/Physician for Procedure: _____

Primary Language: _____ Understands English YES NO Requires Translator YES NO

MEDICAL HISTORY: *Check all that apply* DENIES MEDICAL PROBLEMS

Neurology: Stroke _____ Seizures _____ Depression Head Injury Other _____

Cardiovascular: MI/Heart Attack Hypertension High Blood Pressure Mitral Valve Prolapse
 Heart Valve Replacement _____ CHF Pacemaker Stent Open Heart Surgery _____
 Arrhythmia/Palpitations Internal Defibrillator Manufacturer: _____
 Vascular Disease Peripheral Vascular Disease Coronary Artery Disease _____

EENT: Glaucoma YES NO Loose Teeth YES NO Other _____

Respiratory: Asthma _____ COPD/Emphysema Pneumonia _____ Bronchitis _____
 Sleep Apnea Shortness of Breath Other: _____

Hepatic: Hepatitis Type (*please circle*) A B C Bleeding Disorder: Type _____
 Other Liver Disease: Type _____

GI: GERD (Gastroesophageal Reflux Disease) Hiatal Hernia Ulcer _____ Crohn's/Colitis
 History of Colon Polyps Recent change in Appetite/Weight Trouble Swallowing Other: _____

Renal: Prostate Dialysis, Date of Last Treatment: _____ Kidney Disease: Type _____

Endocrine: Type I Diabetes (Insulin Dependent) Type II Diabetes (Non-Insulin Dependent) Thyroid Disease

Cancer: Type: _____ Date & Type of Treatment: _____

GYN: Last menstrual period: Date _____ Tubal Ligation/IUD Hysterectomy

Musculoskeletal: Arthritis Fractures Back/Disk Disease Artificial Joint/Prosthetic: Type _____
 Limited Motion of Neck TMJ - Limited Jaw Movement

SURGERIES/PROCEDURES: NONE

Procedure	Date

ALLERGIES:

TYPE OF REACTION:

 Medicines Food Environmental Latex No Known Allergies

MEDICATIONS: None See Attach List

Drug	Dosage	Last dosage
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Aspirin in the last week	<input type="checkbox"/> YES <input type="checkbox"/> NO
Coumadin or Plavix in the last week	<input type="checkbox"/> YES <input type="checkbox"/> NO
Motrin, Aleve, Advil in the last week	<input type="checkbox"/> YES <input type="checkbox"/> NO

