34444 King Street Row
Lewes, DE 19958
302-644-3852

HEALTH QUESTIONNAIRE

Please complete this form and bring it with you on the day of your procedure

NAME: ________________________________ PROCEDURE: ___________

EMAIL ADDRESS: __________________________________

Do you have an **Advance Directive** or **Living Will?** Yes___ No ___
If yes, please bring a copy with you. If no, would you like information? Yes___ No___

Nurse's Use Only: Copy on file at Endo Ctr _____ At home _____ Info given _____

Please check if you have / have had any of the following:

Diabetes		Cancer – Type? _________	
If Diabetic, check blood sugar on day of procedure and record here: **Result: _____________ Time: ________**		Thyroid Disease	
		Kidney Disease	
		Liver Disease	
Heart Attack		Hepatitis	
Pacemaker		HIV / AIDS	
AICD		Arthritis	
Cardiac Stents		Seizures	
Atrial Fibrillation		Depression	
Anemia		Anxiety	
High Blood Pressure		Parkinson's	
Stroke		GERD	
TIA		Hiatal Hernia	
Dizziness		Barrett's Esophagus	
Rheumatic Fever		Stomach Ulcers	
Scarlet Fever		Colon Polyps	
Asthma		Diarrhea	
COPD		Constipation	
TB		Crohn's	
Recent Cold / Cough		Ulcerative Colitis	
Sleep Apnea		IBS	
CPAP Use		Weight Loss Surgery/ Medications	
Broken / Loose Teeth		Glasses / Contacts	
Have you fallen in the last three months?		Dentures	
		Hearing Aids	
Females: Any possibility you could be pregnant? ____ Are you breastfeeding? _____			
Do you use:			
Tobacco? Current ______ Former ______ Packs per day? ______ Years? ______			
Marijuana? What form/method? ____________ Last time? ________________			
Recreational Drugs? Type: ________________ Last time? _______________			
Alcohol? Current ______ Former ______ Frequency/Quantity ________________			

Please list any Surgeries:

Procedure	Procedure

Patients may not drive after receiving sedation / anesthesia.

Please list name and contact number for person taking responsibility for you and driving you home after your procedure:

Name: ________________________________ **Number:** _________________________

Please note these important reminders:

- **No Smoking or Tobacco use on day of procedure**
- **No Medicinal or Recreational Marijuana use within 24 hours of procedure**
- **You may not have a taxi, Uber, or bus take you home UNLESS you also have a responsible adult over 18 years riding with you**
- **Contact the office if you are taking weight loss medications or supplements – they might need to be stopped prior to your procedure**

Patient Signature: _______________________________ **Date:** _____________

Please list all medication and food allergies and sensitivities:

Allergies / Sensitivities	Reaction
☐ No know medication allergies	
Are you allergic/sensitive to Latex? Yes ____ No ____ If yes, reaction:	

Please list all medications including vitamins, supplements, weight loss pills, and other over the counter remedies:

Attach additional page if necessary

Medication	Dose	Frequency	Last Taken	Reason for Taking	Restart (Nurse's Use Only)

Patient Signature: ______________________________ **Date:** ____________

Nurse Signature: _______________________________ **Date:** ____________

Physician Signature: ____________________________ **Date:** ____________