ENDOSCOPIC PRE-OPERATIVE QUESTIONNAIRE

Name: _____ DOB: _____

General Practitioner: _____ Location: _____

Health Insurance? Yes / No_____ Pension? Yes / No HCC? Yes / No

History	YES	NO
1. Do you have any medical allergies? (list the type and reaction)	☐	☐
2. Do you have any other allergies including latex, lotion allergy, food? (list the type and reaction)	☐	☐
3. Do suffer from anxiety or phobias?	☐	☐
4. Do you have dentures, crowns, loose teeth, dental issues, etc? (please circle or list)	☐	☐
5. Do you have an advanced care directive (living will) or "power of attorney" in place? If yes, please provide us a copy on or before your procedure date	☐	☐
6. Do you (or have you ever) smoke(d)? If yes, how many per day? ☐ ex-smoker	☐	☐
7. Do you drink alcohol? (how many / how often)?	☐	☐
Cardiovascular Risk	**YES**	**NO**
8. Do you have any heart trouble, eg: chest pain, heart attacks, stents, AF, heart murmur, artificial heart valve, heart operations, pacemaker, or heart defects?	☐	☐
9. Do you have high blood pressure or other blood pressure problems?	☐	☐
Breathing Issues	**YES**	**NO**
10. Do you have breathing problems, eg: Asthma, Bronchitis, Emphysema, chronic lung disease, obstructive sleep apnoea, etc? (please circle or list)	☐	☐
11. Do you get shortness of breath in normal activities (require rest breaks)?	☐	☐
Health Screening	**YES**	**NO**
12. Do you have diabetes? If yes, what type? ☐ Insulin Dependent?	☐	☐
13. Do you have anaemia?	☐	☐
14. Do you have thyroid disease?	☐	☐
15. Have you had a stroke or TIA or other neurological issues?	☐	☐
16. Do you have epilepsy or Parkinson's or another seizure disorder?	☐	☐
17. Do you have any other serious illnesses or other health issues that may impact on your procedure? If yes, please provide details	☐	☐
18. Are you currently pregnant or breastfeeding?	☐	☐
Previous Procedures	**YES**	**NO**
19. Have you had any previous surgeries? If yes, please provide details	☐	☐

20. Have you or anyone in your family had anaesthetic problems? If yes, please provide details	☐	☐
21. Have you had any endoscopic procedures in the past, eg gastroscopy, colonoscopy?	☐	☐
22. Do you have any family history of bowel cancer or bowel polyps?	☐	☐
23. Do you have any joint replacements/metal plates/pins/screws or implants/devices in your body?	☐	☐
Risk Screening	YES	NO
24. Do you use a walking stick or walking frame?	☐	☐
25. Do you get dizzy, lose balance easily or are unsteady on your feet?	☐	☐
26. Do you take medication that leaves you disorientated?	☐	☐
27. Have you had a fall in the last 3 months?	☐	☐
28. Do you currently have a skin ulcer or have had a history of a skin ulcer? (please provide details)	☐	☐
29. Do you have fragile skin or find that your skin bruises or tears easily?	☐	☐
30. Do you require assistance to change position or get in and out of a chair or bed?	☐	☐
31. Have you a past history of deep vein thrombosis (DVT, PE)?	☐	☐
32. Do you have a reliable adult to stay with you for the first night after your operation? (NB: Failure to have a suitable adult to stay with you may result in cancellation of your procedure)	☐	☐
Infection Risk	YES	NO
33. Do you have an artificial heart valve, heart murmur or recent surgery?	☐	☐
34. Do you have hepatitis or HIV?	☐	☐
35. Have you ever had MRSA, VRE, ESBL, C. Difficile diarrhoea, CRE or CPE?	☐	☐
36. Have you been hospitalised in a Health Care Facility overseas in the last 12 months? If yes, which Hospital and discharge date?	☐	☐
Medications	YES	NO
37. Do you take any regular medications? If yes, please list them including dose and time you take them.	☐	☐
38. Are you on Warfarin, Plavix, Xarelto, Pradaxa, Cartia or other blood thinners?	☐	☐