

## GI LAB PATIENT QUESTIONNAIRE

Refer to Reminder below before completing this form. Thank you for choosing Northwestern Memorial Hospital for your GI Lab procedure. **Please fill out this form and bring it with you the day of the procedure.** Please answer each question. This allows us to provide you with the best possible care. (Please Print)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Procedure: \_\_\_\_\_

Primary Care Physician: Name \_\_\_\_\_ Fax Number \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

**Procedure & Related Information:** (\*): procedure normally requires sedation

- |  |  |
|--|--|
| <input type="checkbox"/> Flexible Sigmoidoscopy                        | <input type="checkbox"/> Liver Biopsy*                           |
| <input type="checkbox"/> Colonoscopy*                                  | <input type="checkbox"/> Esophageal/Rectal/Small Bowel Manometry |
| <input type="checkbox"/> Upper Endoscopy*                              | <input type="checkbox"/> 24 Hour Ambulatory pH Study             |
| <input type="checkbox"/> Endoscopic Ultrasound/Fine Needle Aspiration* | <input type="checkbox"/> Other:                                  |
| <input type="checkbox"/> ERCP*   |  |

Reason for visit? \_\_\_\_\_

When was the last time you ate solid food? Date \_\_\_\_\_ Time \_\_\_\_\_

When was the last time you drank liquid? Date \_\_\_\_\_ Time \_\_\_\_\_

If your test required a bowel preparation, what preparation did you take? \_\_\_\_\_

Did you complete the preparation?  Yes  No, how much did you complete? \_\_\_\_\_

On the day of your procedure, will you have any of the following: (Please circle) Dentures, Removable Bridgework, Glasses, Hearing Aide, Walker, Cane, Wheelchair, Prosthetics, Other \_\_\_\_\_

Do you have any body piercings or tattoos? \_\_\_\_\_

Please describe the last time you fell or experienced a fall: \_\_\_\_\_

**Family/Friends/Transportation:**

Who will be waiting for you during the procedure and/or taking you home afterwards?

Name \_\_\_\_\_ Relation \_\_\_\_\_

Daytime contact number(s) \_\_\_\_\_

Verified by Admitting Nurse \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

**Reminder:** Per NMH Policy, if you are having any type or amount of sedation or anesthesia during your procedure, you must have a responsible adult assist you in getting home safely after your procedure. We advise you to have a friend or family member come with you and wait until your procedure is complete. The sedative medication given in the GI lab may affect you up to 24 hours. Walking, taking a bus, or a train alone (without a friend or family member) is not allowed per the policy, even if you live close to the Hospital. If we cannot confirm that you have made safe plans for discharge after your procedure, your procedure will be cancelled. Please call 312.926.7614 if you have any questions or need help arranging a ride home after your procedure.

**Do you take?**

YES NO

Sleeping or Anti Anxiety Medications, Sedatives

YES NO

Prescribed Anticoagulants, Blood Thinners  
Last Dose Taken (Date \_\_\_\_\_ Time \_\_\_\_\_ )

Aspirin or Non-steroidal Anti-Inflammatory Drugs

Insulin or pills to control your blood sugar

**Please fill out the PATIENT MEDICATION LIST and bring it with you the day of your procedure.**

**Past/Present History:**

YES NO

Are you currently experiencing pain? \_\_\_\_\_

Is your pain chronic? \_\_\_\_\_ Location \_\_\_\_\_

Please rate your pain - 0(no pain) to 10(worst pain) \_\_\_\_\_

Have you ever had reactions to the medications given to you during any procedures or surgery?

Please describe: \_\_\_\_\_

Allergies (such as drug, food, latex) Please list \_\_\_\_\_

Reaction \_\_\_\_\_

Have you ever fainted, felt dizzy or nauseous after having your blood drawn or an IV started?

Please describe: \_\_\_\_\_

Diabetes: If yes, do you take insulin or pills? \_\_\_\_\_

Did you take your blood sugar the day of your procedure? \_\_\_\_\_

Time taken and results \_\_\_\_\_

High blood pressure: Is your blood pressure controlled by medication? \_\_\_\_\_

Do you take antibiotics prior to medical or dental procedures? Antibiotic and dose \_\_\_\_\_

Heart Problems \_\_\_\_\_

Heart pacemaker, implanted cardiac defibrillator \_\_\_\_\_

Lung disease: (such as Asthma, Emphysema) \_\_\_\_\_

Sleep Apnea \_\_\_\_\_

Cancer - Location \_\_\_\_\_

Kidney Disease \_\_\_\_\_

Neurological Problems: (such as Seizures) \_\_\_\_\_

Gastrointestinal Disease or Symptoms: (such as Reflux, Crohn's Disease, Ulcerative Colitis) \_\_\_\_\_

Liver Disease: (such as cirrhosis, hepatitis) \_\_\_\_\_

Glaucoma \_\_\_\_\_

Smoking/Tobacco Use: How much per day? \_\_\_\_\_

Alcohol/Substance Use: How much per day? \_\_\_\_\_ Last Drink \_\_\_\_\_

Are you pregnant - When was your first day of your last Menstrual Cycle? \_\_\_\_\_

Are you breastfeeding? \_\_\_\_\_

Other: (such as arthritis, blood disorders, infectious diseases) \_\_\_\_\_

Do you follow a special diet for medical reasons? (For example, gluten free) \_\_\_\_\_

Please list your surgeries: \_\_\_\_\_

Have you visited a GI Lab in the past? If so, please list the procedure(s) you have had and the year it took place:

**Patient**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of**

**Admitting Nurse:** \_\_\_\_\_ **Date:** \_\_\_\_\_

