Brigham and Women's Hospital
Founding Member, Mass General Brigham

RIDE CONFIRMED BY STAFF
EMPLOYEES INITIALS:_____

PLEASE COMPLETE AND BRING WITH YOU TO YOUR APPOINTMENT

SOUTH SHORE ENDOSCOPY CENTER
659 WASHINGTON STREET
BRAINTREE, MA 02184
781-849-9577

PATIENT NAME:_____

PRE-ADMISSION QUESTIONNAIRE

PRIMARY CARE PHYSICIAN: _____ ENDOSCOPIST: _____

PROCEDURE: _____ REASON FOR PROCEDURE: _____

MAY WE LEAVE MESSAGES ON AN ANSWERING MACHINE/VOICEMAIL? YES NO

MAY WE DISCUSS YOUR PROCEDURE WITH ANYONE OTHER THAN YOU? _____

WE *MUST* HAVE THE NAME *AND* TELEPHONE NUMBER OF THE PERSON WHO WILL BE DRIVING YOU HOME AFTER THE PROCEDURE:
NAME: _____ TELEPHONE #: _____

PLEASE MARK THE FOLLOWING APPROPRIATELY:

YES	NO	PERSONAL HISTORY(SELF)	EXPLAINATION, IF YES
_____	_____	HEART DISEASE	_____
_____	_____	HIGH BLOOD PRESSURE	_____
_____	_____	BREATHING/LUNG PROBLEMS	_____
_____	_____	SEIZURES/STROKE/EPILEPSY	_____
_____	_____	LIVER/KIDNEY DISEASE	_____
_____	_____	HISTORY IF CANCER(SELF)	_____
_____	_____	DIABETES	_____
_____	_____	THYROID PROBLEMS	_____
_____	_____	ARTHRITIS/LIMITATIONS OF MOVEMENT	_____
_____	_____	DIARRHEA/CONSTIPATION	_____
_____	_____	TROUBLE SWALLOWING/FOOD STICKING	_____
_____	_____	SMOKE/DRINK ALCOHOL – IF YES, AMOUNT	_____
_____	_____	PREGNANT	_____

ANY OTHER MEDICAL PROBLEMS NOT LISTED ABOVE? _____

_____

ANY SURGICAL OPERATIONS? _____

_____

HAS THE PATIENT HAD ANY PROBLEMS WITH ANESTHESIA OR SEDATION? _____YES _____NO, EXPLAIN_____

_____

-OVER-

HAS THE PATIENT EVER BEEN HOSPITALIZED FOR ANY REASON OTHER THAN SURGERY? _____YES _____NO, EXPLAIN_____

_____

ALLERGIC REACTIONS TO MEDICATIONS? _____YES _____NO IF YES, GIVE MEDICATION AND TYPE OF REACTION

_____

ALLERGIC REACTIONS TO OTHER MATERIALS? _____YES _____NO IF YES, GIVE MATERIAL NAME AND TYPE OF REACTION (I.E,

LATEX, IODINE, FOOD, ETC.) _____

PRESCRIPTION MEDICATIONS

MEDICATON	STRENGTH	TIMES	LAST DOSE	MEDICATON	STRENGTH	TIMES	LAST DOSE

NON-PRESCRIPTION MEDICATIONS (I.E. HERBS, VITAMINS)

MEDICATON	STRENGTH	TIMES	LAST DOSE	MEDICATON	STRENGTH	TIMES	LAST DOSE

DO YOU HAVE ANY OF THE FOLLOWING?

YES **NO**

_____ _____ EYEGLASSES/CONTACTS

_____ _____ DENTURES/BRIDGE

_____ _____HEARING AIDS

_____ _____ ASPIRIN WITH THE LAST WEEK

_____ _____ *DO YOU HAVE AN ADVANCED DIRECTIVE SUCH AS A HEALTH CARE PROXY

ANY ADDITIONAL INFORMATION/FAMILY HISTORY THAT WILL BENEFIT YOU PROCEDURE

_____

_____

_____

_____

_____

_____

PATIENT/AUTHORIZED SIGNATURE

_____ PATIENT _____ POWER OF ATTORNEY

_____ PARENT _____ LEGAL GUARDIAN

****PLEASE BRING THIS FORM, YOUR INSURANCE CARD(S), YOUR DRIVERS LICENSE AND A LIST OF ALL YOUR MEDICATIONS WITH YOU.**

****YOU MUST HAVE A RIDE HOME WITH A RESPONSIBLE ADULT; A TAXI WITH A RESPONSIBLE ADULT (NOT THE TAXI DRIVER) IS ALLOWED. "THE RIDE" IS NOT AN ACCEPTABLE FORM OF TRANSPORTATION.**

****YOUR RIDE MUST ACCOMPANY YOU OR BE AVAILABLE BY PHONE AT TIME OF CHECK IN.**

****IF YOU HAVE AN ADVANCE DIRECTIVE PLEASE BRING WITH YOU TO YOUR PROCEDURE.**