



GSAA Gastroenterology Pre-Sedation Questionnaire

Please answer the questions below prior to arriving for you gastroenterology procedure so that we can expedite your appointment and provide you with the very best care possible. Thank you.

1. Name: _____ MRN: _____
2. Age: _____ Height: _____ Weight (lbs.): _____ Dr. seeing you: _____
3. Last time you ate or drank anything prior to procedure: _____
4. Do you smoke? If yes, how many packs per day? _____
5. When was the last time you drank alcohol: _____
6. Do you have an Advanced Directive? (legal document giving someone authority to make medical decisions for you): _____ If yes, is there a copy in your medical records? _____
7. If female, are you pregnant? _____
8. Have you ever had any previous sedation or anesthesia? _____ If yes, have you had any problems with sedations? _____
9. Name of person giving you transportation home after procedure:

- Their relationship to you: _____ Their phone number _____
10. List any allergies to medications, foods or latex: _____

11. List your current medications that you are taking:

Medication	Dose	Usual times taken	Last time taken

12. Please check off if you have any of the following medical conditions:

<input type="checkbox"/> Bleeding cancer	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Lung disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Implantable devices	<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Snoring
<input type="checkbox"/> Stroke		