Northwestern Medicine®
Northwestern Memorial Hospital

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** _____

Name of Primary Care Physician _____ **Fax Number** _____

Address _____ **Phone Number** _____

Procedure and Related Information: *** Procedure normally requires sedation**

- ☐ Flexible Sigmoidoscopy
- ☐ Colonoscopy*
- ☐ Upper Endoscopy (EGD)*
- ☐ Endoscopic Ultrasound/Fine Needle Aspiration*
- ☐ ERCP*
- ☐ Liver Biopsy*
- ☐ Esophageal/Rectal/Small Bowel Manometry
- ☐ 24-hour Ambulatory pH Study
- ☐ Other _____

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 _____

Family/Friends/Transportation:

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

Name _____ Relationship _____

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, you must have a responsible adult to accompany you home after the procedure. This person must pick you up in the GI Lab. If you have another doctor's appointment or any other testing at Northwestern Memorial Hospital after your GI Lab procedure, a responsible adult must escort you out off the GI Lab and to your appointment. You **may not** walk, take a taxi or any public transportation home unless your are accompanied by a responsible adult. If our staff cannot confirm that you have made safe plans for discharge after your procedure, your procedure will be cancelled. If you will need assistance getting home after your GI Lab procedure, you can arrange a ride home with Superior Ambulance Company by calling **312-926-5988**. There is a base rate for the service. There is also a per mile fee that will be charged in addition to the base rate for each mile traveled. Payment is required at the time of service (cash or credit cards are accepted). If you have made transportation arrangements with Superior Ambulance for your discharge home, please inform the GI Lab staff on the day of your procedure.

→ Complete both sides of form

Do you take?

YES	NO		YES	NO	
☐	☐	Sleeping or Anti-anxiety Medications, Sedatives	☐	☐	Prescribed Anticoagulants, Blood Thinners Last Dose Taken (Date _____ Time _____)
☐	☐	Aspirin or Non-steroidal Anti-inflammatory Drugs	☐	☐	Insulin or pills to control your blood sugar

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 or has anyone in your family 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 experienced a fall in the last 12 months? Please describe _____
☐	☐	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 level 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 _____
☐	☐	Have you had a hysterectomy? _____ For women ages 12–50, when was the first day of your last menstrual period? _____
☐	☐	Are you pregnant or trying to become pregnant? _____
☐	☐	Is there a possibility that you might be pregnant? _____
☐	☐	Other (such as arthritis, blood disorders, infectious diseases, breast feeding) _____
☐	☐	Do you follow a special diet for medical reasons? (For example, gluten-free) _____

Please list your surgeries _____

_____

Please list the date of your last colonoscopy and/or upper endoscopy (EGD) _____

Patient Signature _____ **Date** _____ **Time** _____

Signature of Admitting Nurse _____ **Date** _____ **Time** _____