

Digestive Disease Associates of Rockland, PC
974 Rte. 45, Pomona, NY 10970
(845) 354-3700

Patient's Name _____ Date _____

PRE-PROCEDURE PATIENT QUESTIONNAIRE

***IF YOU ANSWER YES TO ANY OF THESE QUESTIONS, YOU MUST CONTACT THIS OFFICE IMMEDIATELY FOR FURTHER INSTRUCTIONS.
ASK TO SPEAK WITH scheduling secretary at ext. 218***

1. Do you have diabetes? YES ____ NO ____
2. Do you take antidepressant medications such as Nardil or Parnate?
YES ____ NO ____
3. Do you take anticoagulants (eg: coumadin, warfarin) or aspirin, Advil (ibuprofen) or Plavix?
YES ____ NO ____
4. Do you have a tendency towards bruising? Do you have any bleeding disorders such as hemophilia or Von Willebrand's disease?
YES ____ NO ____
5. Do you require antibiotics before undergoing medical or dental procedures?
YES ____ NO ____
6. Do you have any artificial joints or artificial heart valves?
YES ____ NO ____
7. Do you have any breathing problems or require the use of oxygen?
YES ____ NO ____
8. Do you have an implanted device? i.e. Defibrillator
YES ____ NO ____
9. Have you ever had rheumatic fever, rheumatic heart disease or congenital heart disease such as mitral valve prolapses?
YES ____ NO ____
10. Have you ever had a reaction to general anesthesia, Valium, Versed, Demerol?
YES ____ NO ____
11. Are you pregnant? YES ____ NO ____
**Women: If you are under the age of 55, we will perform a urine pregnancy test.
Please come with a full bladder so you will not have difficulty urinating.**
12. Do you suffer from sleep apnea? YES ____ NO ____