NEW YORK GASTROENTEROLOGY ASSOCIATES

Patients Name _____
Patients Date of Birth _____
Scheduled Procedure Date _____
Performing Provider _____

Pre-Procedure Medical Clearance Questions

1. Have you had a heart attack or a stroke within the last 6 months?

   Yes No

2. Have you had cardiac stents placed within the last 3 months?

   Yes No

3. Do you have cardiac chest pain on a regular or worsening basis?

   Yes No

4. Do you have congestive heart failure?

   Yes No

5. Do you have severe heart valve disease?

   Yes No

6. Have you been on Dialysis?

   Yes No

7. Do you have COPD?

   Yes No

8. Do you have sleep apnea?

   Yes No

9. Have you had previous issues during anesthesia?

   Yes No

10. Do you have any significant heart, lung, liver or kidney disease?

    Yes No

11. Do you take any blood thinner?

    Yes No