

Colon and Rectal Clinic of Orlando

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Pre-Endoscopy Questionnaire

Date: \_\_\_\_\_

Patient's name: \_\_\_\_\_

Current address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Doctor you see at the Colon and Rectal Clinic

Williamson Ferrara Gallagher DeJesus

1. Are you taking Coumadin, Aspirin, or any blood thinners? Yes No

If yes which one(s): \_\_\_\_\_

2. Have you had a heart attack, angina, lung or breathing problems over the last year?

Yes No

If yes explain: \_\_\_\_\_

3. Do you have a pacemaker or defibrillator? Yes No

**If yes please attach card**

4. Have you had any illness over the last year: Yes No

If yes explain: \_\_\_\_\_

5. Do you clot well when cut? Yes No

6. Do you have any allergies? Yes No

If yes explain \_\_\_\_\_

7. What medications are you taking now? Yes No

If yes explain: \_\_\_\_\_

**8. PLEASE ATTACH FRONT AND BACK COPIES OF YOUR INSURANCE CARDS**

Doctor's signature \_\_\_\_\_