Pre-Consult Questionnaire

Name: ..... **DOB**.....

What condition are you here for today?

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Have you had any significant past medical illnesses?

- Diabetes.....
- Heart Conditions.....
- Lung Conditions.....
- Kidney Failure.....
- Sleep Apnoea.....
- Epilepsy.....
- Other.....

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Name of other specialists and treating doctors

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Past Operations/Surgery and year of surgery

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What medications are you taking?

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Do you have a significant allergy? Yes / No

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Do you smoke? Yes .....pkts/ day No

Have you ever smoked and how much?.....

Do you drink alcohol? Yes / No. How much per week?

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Do you have a family history of stomach or bowel cancer?

If yes, who and at what age were they diagnosed?

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