



COLUMBIA UNIVERSITY
MEDICAL CENTER

David D. Markowitz, M. D.
Associate Clinical Professor of Medicine
161 Ft. Washington Ave., Suite 853
New York, NY 10032
T (212) 305 – 1024
F (212) 305 – 1039

Diagnostic Upper Endoscopy Questionnaire

Patient Name: _____ **Birth Date:** _____ **Age:** _____

Date of Exam: _____ **Referring Physician:** _____

Referring Physician Name
Address/Telephone: _____

Indication/Symptoms: _____

Allergies: _____ **Prior Endoscopy?** Y N

If Yes, Date of last test: _____ **Findings:** _____

Are you taking Aspirin or Coumadin Medications? Y N **Specify:** _____

Personal or Family History of the following:

- | | | |
|--|---|-------------|
| <input type="checkbox"/> Colon or GI Cancer | <input type="checkbox"/> Personal <input type="checkbox"/> Family | Type: _____ |
| <input type="checkbox"/> Reflux | Frequency: _____ | |
| <input type="checkbox"/> Difficulty swallowing | Frequency: _____ | |
| <input type="checkbox"/> Abdominal Pain | Frequency: _____ | |

Please list any other Medical Problems or Conditions:

