GASTROENTEROLOGY CONSULTANTS PC

BRUCE A SALZBERG MD, FACG

678-957-0057 fax 678-957-0047

Email denise@gastroenterologyconsultants.net

FAST ACCESS COLONOSCOPY

MEDICAL QUESTIONNAIRE FOR SCREENING COLONOSCOPY

Today's Date: _____

Name: _____ Age:_____ Date of Birth:_____

Sex: M / F Weight _____ If over 350 lbs please contact office

When would you prefer to schedule procedure_____?

Which office? Alpharetta St Josephs

Occupation:_____

Referring physician _____

The reasons for the colonoscopy are (check all that apply):

Screening (age over 50) _____ African American over 45 _____

Family history of colon cancer _____

Polyps removed at a previous colonoscopy _____

Previous colorectal cancer _____

Hidden blood found in stool _____

Blood test abnormality _____

History of Ulcerative colitis or Crohn's Disease_____

Symptoms: Rectal bleeding _____

Change in bowel habits _____

Constipation _____

Diarrhea_____

Have you ever had a colonoscopy before? Yes No

When _____

Who performed the procedure _____

Findings _____

Do you experience frequent heartburn or difficulty swallowing? Yes No

If so, have you had a prior endoscopy? Yes No When_____ Findings_____

List Medications you are currently taking

_____

_____

_____

_____

_____

Are you taking Blood thinners Coumadin, Plavix, Aggrenox, Pradaxa, Eliquis, ASA ,

Anti-inflammatory medication (Advil,Nupren,ibuprophen etc.)

Yes _____ which ones_____

No

Medication Allergies Please list ______

If you have had a colonoscopy previously, did you have any problem with the bowel prep? _____

Do you recall the prep _____

With the sedation? _____

Any problems afterwards? _____

Do you have difficulty breathing (asthma, COPD, emphysema)? _____

Do you use supplemental oxygen? _____

Have you ever had a problem with a sedative or anesthesia?

_____

Are there any problems with your kidney function (renal failure)? _____

Have you had problems with low or high potassium or calcium in your blood? _____

Do you have an implantable defibrillator? _____ Do you have a pacemaker? _____

Have you been troubled by chest pain, chest pressure or smothering in the past year? _____

Have you ever had a heart attack?_____If so when _____

Have you had cardiac stents inserted _____If so when _____

Do you have atrial fibrillation? _____ Do you have any other abnormal heart rhythm? _____

Are you aware of any problem with the valves of your heart or have you had heart valve surgery? _____ Do you need antibiotics for procedures? _____

Do you smoke cigarettes? Present past How many per day? _____

For how many years? _____

How many alcoholic beverages do you consume in a week _____

Has either a parent, brother, sister, child or grandparent had cancer of colon or rectum? _____

If yes, what relationship and at what age was that person diagnosed? _____

Have parents or siblings had colon polyps? _____ Who?

_____

Please list all previous surgeries (include approximate dates)

_____

_____

Other than for surgeries, have you ever stayed overnight in a hospital? _____ If so, please give the medical conditions that were treated and approximate dates:_____

_____

Have you ever been diagnosed with cancer?_____If yes, please provide primary organ involved and date first diagnosed as well as treatment and current status

_____

_____

My typical bowel pattern is:

(a) 1-2 per day_____

(b) 1 every other day

(c) 2-3 per week_____

(d) 1 per week_____

(e) 1 every 2 weeks_____

(f) 3 or more per day (give number) _____

Please circle those problems that have been present in the past year:

Fatigue
Weakness
Poor appetite
Unexplained fever
Night sweats
Malaise (just feel blah)
H.I.V.
Glaucoma
Double vision
Major vision loss
Hearing loss
Ringing in ears
Nasal congestion
Sinus problems
Diabetes
High thyroid
Low thyroid
Goiter
Tuberculosis
Kidney Stones
Kidney failure
Dialysis
Abdominal hernia
Anemia (low blood)
Low iron
Low platelets
Easy bleeding
Thalassemia
Blood clot in legs
Aneurysm
Stroke
TIA (transient ischemic attack)
Continuous weakness of a limb
Continuous loss of sensation of a limb
Multiple sclerosis
Frequent headaches (non-migraine)
Migraine headaches
Cluster headaches
Drug dependence

Bronchitis
Asthma
Emphysema
Chronic cough
Blood clot in lung
Coughing up blood
Shortness of breath
High blood pressure
Low blood pressure
Fainting
Chest pain
Angina
Congestive heart failure
Palpitations
Abnormal heart rhythm
Mitral valve prolapse
Rheumatic heart disease
Difficulty urinating
Burning when urinating
Muscle weaknessAwakening to urinate
SeizuresBlood in urine
Frequent numbness
Restless legs
Osteoarthritis
Rheumatoid arthritis
Other arthritis
Osteoporosis
Back pain
Neck pain
Fibromyalgia
Difficulty sleeping
Sleep apnea
Depression
Anxiety
Bipolar disorder
Hallucinations
Suicidal thoughts
Alcohol

WOMEN ONLY:
Endometriosis
Heavy menstrual periods
Very painful menstrual periods
Ovarian cysts
Pain during intercourse
Pelvic pain

MEN ONLY:
Difficulty with erection
Mass in testicles
Pain in testicles
Prostate cancer
Prostate enlargement

If you think you have a significant medical problem that was not covered on this form, please list below: