FAST ACCESS COLONOSCOPY

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MEDICAL QUESTIONNAIRE FOR SCREENING COLONOSCOPY

Date: _____

Name: _____ Age: _____ DOB: _____ Phone:

Sex: M / F **WEIGHT**: _____ If over 350lbs please contact the office

Occupation:

When would you prefer to schedule procedure:_____

Which office? Alpharetta St Josephs (Sandy Springs)

Referring physician: _____

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

Screening (age over 45) _____

Family history of colon cancer: _____ If so who in your family and what age:

Personal history of colorectal cancer:

Hidden blood found in stool:

Cologuard Test:

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

If yes, When:

Who performed the procedure:

Findings:

If polyps were found, were they precancerous? Yes No

Any complications of the procedure? Yes No

Do you suffer from heartburn, GERD or trouble swallowing? (Circle one)

Have you ever had an upper endoscopy?_____If so when?_____

List Medications you are currently taking:

Do you have any of the following? (Circle)

Hypertension Coronary Artery Disease Valvular Heart Disease COPD Stroke

Hepatitis AIDS or HIV Diverticulitis Thyroid Disease Asthma Chronic Renal Failure

Transplant TIA Seizures MS Venous thrombosis Embolism

MUST ANSWER- Are you taking Blood Thinners? (Ex: **Coumadin, Plavix, Aggrenox, Pradaxa, Eliquis, ASA)**

Please circle one or circle NO

Anti-inflammatory medication: (Ex: Advil, Nupren, ibuprofen etc.) If

yes, which ones: _____ Or circle: No

Medication Allergies:

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? Yes No

Have you ever had a problem with sedation or anesthesia? Yes No

MUST ANSWER- Are there any problems with your kidney function (renal failure) Yes No

Have you had problems with low or high potassium or calcium in your blood? Yes No

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? Yes No

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? Yes No

Do you smoke cigarettes? Present Past No

How many per day? _____ For how many years? _____

How many alcoholic beverages do you consume in a week: _____

Have parents or siblings had colon polyps or colon cancer: _____

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? Yes No

If yes, please provide primary organ involved and date first diagnosed as well as treatment and current status:

<u>My typical bowel pattern is:</u>

(a) 1-2 per day

(b) 2-3 per week

(c) 1 per week

(d) 1 every 2 weeks

(e) 3 or more per day (give number)

Is there anything else we should know in advance about your personal or past medical history? If so please be very specific:

Please Fax the completed forms to Savannah- 678-957-0047.

PLEASE FAX THE FRONT AND BACK OF YOUR INSURANCE CARD TO SAVANNAH AT 678-957-0047.

You will receive a call back within 48 hours to schedule after Dr. Salzberg reviews the questionnaire.