



# FAST ACCESS COLONOSCOPY

## Atlanta Gastroenterology Specialists PC

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*(Please email paperwork along with the front and back of your insurance card.)*

### MEDICAL QUESTIONNAIRE FOR SCREENING COLONOSCOPY

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

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: M / F      Weight \_\_\_\_\_ If over 350 lbs. please contact office

When would you prefer to schedule to procedure \_\_\_\_\_?

Occupation: \_\_\_\_\_

Referring physician, \_\_\_\_\_

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

Screening (age over 45) \_\_\_\_\_ The American Cancer Society has revised the age for screening to 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 tests: Positive Negative

Blood test abnormality \_\_\_\_\_

History of Ulcerative colitis or Crohns 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 \_\_\_\_\_

If polyps were found were they precancerous? \_\_\_\_\_

Any Complications of the procedure? \_\_\_\_\_

Do you suffer from heartburn, GERD or trouble swallowing? \_\_\_\_\_

Have you ever had an upper endoscopy? \_\_\_\_\_ If so when? \_\_\_\_\_

List Medications you are currently taking:

Do you have any of the following? (Please circle )

Hypertension      Coronary Artery Ds      Valvular Heart Ds      COPD  
Hepatitis      AIDS or HIV      Diverticulitis      Thyroid ds      Asthma Chronic Renal Failure  
Transplant S t r o k e      TIA      Seizures      MS      Venous thrombosis Embolism

MUST ANSWER: Are you taking Blood thinners (Ex:Coumadin, Plavix, Aggrenox, Pradaxa, Eliquis, ASA, etc.)

Please circle one or circle NO

Anti-inflammatory medication (Advil, Nupren, Ibuprofen 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 sedation or anesthesia?

\_\_\_\_\_

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 or 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? \_\_\_\_\_

Do you smoke cigarettes? Present past 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? \_\_\_\_\_ If yes, please provide primary organ  
involved and date first diagnosed as well as treatment and current status

\_\_\_\_\_

\_\_\_\_\_

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) 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 678-957-0047.

Or email to [fastaccess@atlgastrspec.com](mailto:fastaccess@atlgastrspec.com)

You will receive a call back within 48 hour to schedule after Dr. Sangha reviews the questionnaire If you do not hear from us please call the office

Please Note:

Screening colonoscopies are usually fully covered by insurance if you meet their criteria, though this is not always guaranteed. If you have any preexisting conditions, your insurance may classify the procedure as diagnostic. We will work with your insurance to precertify the procedure and will inform you of any financial responsibility. If a polyp or other abnormality is discovered during the procedure, we will adjust the coding to indicate that the intent was a screening. However, please note that this may lead to additional charges based on your insurance policy. If you have any questions, feel free to contact our office.

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