FAST ACCESS COLONOSCOPY

GASTROENTEROLOGY CONSULTANTS PC

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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 procedure____________________?

Which office? Alpharetta St Josephs (Sandy Springs)

Occupation:________________________

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 tests_________

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 Stroke TIA Seizures MS Venous thrombosis Embolism

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

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 sedation 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 _________

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

____

____

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

____

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Please Fax the completed forms to Denise 678-957-0047. You will receive a call back within 48 hrs to schedule after Dr. Salzberg reviews the questionnaire