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SCREENING COLONOSCOPY QUESTIONNAIRE

Primary Physician Name: ____ Office Tel #: __________________________

Patient Name: ____ DOB: ________________ Age: ______

Patient Phone #: ___________________________ Weight: ___________Lbs. BMI: __________

Primary Language: ☐Spanish ☐ English Pharmacy Tel #: ____________________________

INDICATION

- ☐Asymptomatic screening, age > 45 yo
- ☐Hemoccult positive stool or Cologuard positive
- ☐Rectal bleeding
- ☐Prior history of colon polyps (date of last colonoscopy: _________________, Dr. ____________________, attach report)
- ☐Prior history of colon cancer (attach records)
- ☐Family history of colon cancer (family member(s) ___________________, age at diagnosis _______)
- ☐Other: ____.

HISTORY

- ☐Heart attack/heart disease
- ☐Artificial Valve
- ☐Use of aspirin/NSAID's
- ☐Use of blood thinners
- ☐Lung disease
- ☐Stroke
- ☐Joint replacement
- ☐Coronary stents or bypass surgery (date: _______________)
- ☐Pacemaker/defibrillator
- ☐Bleeding disorder
- ☐Smoker
- ☐Seizures
- ☐Reaction to anesthesia
- ☐Dialysis Patient
- ☐Anemia
- ☐Sleep apnea
- ☐Diabetes
- ☐Alcohol in excess
- ☐Illicit drugs
- ☐Use of Oxygen

EXCLUSION CRITERIA

- ☐Heart Surgery or MI <6months ago
- ☐Use of blood thinners (except ASA)
- ☐Chest Pain
- ☐Shortness of breath
- ☐EF less than 30%
- ☐Stroke < 6 months ago
- ☐Cardiac Tests Pending
- ☐Pacemaker unchecked ≥ 1 yr.
- ☐Defibrillator
- ☐Hx. of Malignant Hyperthermia
- ☐BMI>50
- ☐Uncontrolled Blood Pressure >160/100
- ☐Uncontrolled Diabetes Mellitus
- ☐Pregnant
- ☐Dialysis Patient

Primary Physician Signature: ____ Date: ___________________

Please include demographics and last office notes.