OPEN ACCESS COLONOSCOPY PATIENT QUESTIONNAIRE

First Name _____ M. I. _____ Last name _____

Sex _____ (M) _____ (F) DOB _____ SSN _____

Marital Status _____ Race _____ Preferred Language _____

Height _____ **Weight** _____ Employer _____

Mailing Address _____

Billing Address _____

County _____ Email address _____

Home Phone _____ Work Phone _____

Cell Phone _____ (circle best contact number)

Emergency contact

Name _____ Relationship _____ Phone Number _____

Referring Physician

Name _____ Phone Number _____

Primary Care Physician

Name _____ Phone Number _____

Preferred Pharmacy

Name _____ Phone Number _____

Address _____ City _____

Primary Insurance

Name of Insurance _____ Precertification Phone Number _____

Claims address _____

Policy Number/Member ID_____ Group Number _____

Policy Holders Name _____ Relationship _____

SSN _____ DOB _____ Employer _____

Secondary Insurance

Name of Insurance _____ Precertification Phone Number _____

Claims address _____

Policy Number/Member ID_____ Group Number _____

Policy Holders Name _____ Relationship _____

SSN _____ DOB _____ Employer _____

_____ Check here if uninsured and would like to discuss payment options

Health Questions

Do you have **persistent** or **recurring** problems, or a **history** of the following?

General:
_____ Dizziness _____ Fatigue _____ Fever _____ Wheelchair Bound
_____ Unexplained Weight Loss _____ lbs
_____ Unexplained Weight Gain _____ lbs

GI:
_____ Abdominal Pain _____ Constipation _____ Diarrhea _____ Nausea
_____ Heartburn/Reflux _____ Difficulty/Painful Swallowing _____ Vomiting
_____ Rectal Bleeding/Blood in Stool _____ Ulcerative Colitis _____ Crohn's
_____ Liver Disease
_____ Intestinal Surgery in the last 6 months (what & when) _____
Have you ever had a colonoscopy? When? Where? _____
Have you ever had polyps or colon cancer? _____
Any relatives with colon cancer? Who and what age were they?
_____

Hematologic:
_____ Anemia (recent treatment) _____ Free Bleeder/Hemophiliac
_____ Take any Blood Thinners Such As Plavix, Coumadin, Warfarin, Effient, Lovenox, etc.

Neurologic:
_____ Stroke/TIA-when and do you have any weakness leftover _____
_____ Seizure-when was last one_____

Cardiovascular:
_____ Chest Pain/Pressure/Heaviness _____ Irregular Heart Rhythm
_____ High Blood Pressure _____Bypass-When_____ _____Valve surgery
_____ Heart Attack/MI-when _____ _____ Stents placed-When _____
_____ Defibrillator and/or Pacemaker - What Brand?_____
_____ Congestive Heart Failure – When _____

ENT:
_____ Hard of Hearing _____ Unexplained Vision Changes _____ Glaucoma

Genitourinary:
_____ Kidney disease/failure _____ Diabetes _____ Insulin _____ oral meds
_____ Dialysis- What kind:_____

Psychological:
_____ Depression _____ Anxiety/Panic Attacks _____ Dementia/Memory Loss
_____ Other Mental Illness - what kind_____

Respiratory:
_____ Sleep Apnea CPAP _____ Shortness of Breath _____ Asthma (recent treatment)
_____ COPD/Emphysema/Chronic Bronchitis _____ On Oxygen-How many liters and when_____

Have you been hospitalized within the last month? Why? _____
Have you ever had problems with anesthesia? Please Describe _____
Have you ever had an organ transplant? What & When? _____

Other Medical History:
_____
_____

Previous Surgeries and Dates:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Allergies to Medications, Foods, or Latex:

	Name	Reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

*add additional allergies to the blank area below.

Medications (prescription or over the counter including vitamins, etc.):

	Name	Dosage	How often
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____
13.	_____	_____	_____
14.	_____	_____	_____
15.	_____	_____	_____

*add additional medications to the blank area below.

I understand that if I have not answered these questions honestly and to the best of my knowledge, it could result in complications during my procedure.

Patient signature _____ Date: _____

Please return this completed form. You will receive a call from one of our schedulers to schedule your colonoscopy or an office visit. If you would like to speak with one of our open access schedulers, please call us at 864-678-8191.

Mail form to: **Open Access Program**
Gastroenterology Associates, PA
200 Patewood Drive, Suite B200
Greenville, SC 29615

Or fax to: **864-451-5187**