OPEN ACCESS PATIENT QUESTIONNAIRE

see SUBMIT options on last page

Name: _____
(Last) (First) (Middle) (Nickname)

SS#: _____ DOB: _____ Age: _____ Sex: ☐ M ☐ F

American Cancer Society recommends screenings at age 45, most insurance plans start covering at age 50.

Billing Address: _____
(Street or PO Box) (City) (State, Zip)

Secondary Address: _____
(if different than above) (Street or PO Box) (City) (State, Zip)

County: _____ Marital Status: _____

Race(check one): ☐White ☐Black or African American ☐ Hispanic ☐ American Indian or Alaska Native
☐Native Hawaiian or Other Pacific Islander ☐Asian ☐Other Race ☐Declined to specify

Ethnicity (check one): ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Specify

Preferred Language: _____ Employer: _____

Appointment reminders by: (select one) ☐Phone Call ☐Email ☐Text (SMS)

(circle best contact number)

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Email: _____
(please provide so we can invite you to our patient portal)

Emergency Contact: _____
(Name) (Relationship) (Phone #)

Primary Care Doctor: _____ Referring Doctor: _____

Preferred Pharmacy: _____ Pharmacy Phone #: _____

Pharmacy Address: _____
(Street or PO Box) (City) (State, Zip)

☐ No medical insurance and would like to discuss payment options.

Primary Insurance Coverage

Name of Insurance: _____ Member ID # _____ Group # _____

Claims Filing Address: _____ Precert. Phone# _____

Subscriber Name: _____ DOB: _____ Relationship: _____

Subscriber Employer: _____ SS#: _____

Secondary Insurance Coverage (if applicable)

Name of Insurance: _____ Member ID # _____ Group # _____

Claims Filing Address: _____ Precert. Phone# _____

Subscriber Name: _____ DOB: _____ Relationship: _____

Subscriber Employer: _____ SS#: _____

Medical/Health Questions

Screening colonoscopies are considered preventative services. However, be sure to contact your insurance company to verify coverage of colon cancer screenings. It is the patient's responsibility to confirm eligibility. We will submit all insurance claims on your behalf as long as all necessary information was provided.

Are you prescribed any blood thinners? ☐Yes ☐No
(Plavix, Brilinta, Integrilin, Aggrastat, Aggrenox, Ticlid, Pletal, Pradaxa, Savaysa, Elmiron, Fragmin, Tikosyn, Coumadin, Warfarin, Eliquis, Effient, Lovenox, Xarelto)?

Height:	**Weight:**	****Height AND weight MUST BE accurate.** **Patient BMI determines the most appropriate location for procedures. Procedures will be canceled if BMI does not meet procedure center guidelines.**

Unexplained weight gain?	☐Yes ☐No	lbs	Unexplained weight loss?	☐Yes ☐No	lbs	**Are you taking any weight loss medications?** (Phentermine, Benephetamine, Phendimetrazine, Phenemine, Contrave) ☐Yes ☐No

Are you currently wheelchair bound? ☐Yes ☐No

Current or recurring symptoms/conditions: (check all that apply)

Gastrointestinal:

☐Abdominal pain
☐Constipation
☐Diarrhea
☐Rectal bleeding/Blood in stool
☐Nausea
☐Vomiting
☐Heartburn/Reflux
☐Difficulty/Painful Swallowing
☐Ulcerative Colitis
☐Crohn's Disease
☐Liver Disease

Intestinal surgery in last 6 months? ☐Yes ☐No	List surgery _____ When? _____
Previous Cologuard, FIT, or FOBT Test? ☐Yes ☐No	When? _____ Results? _____
Previous colonoscopy ☐Yes ☐No	When? _____ Where? _____
Have you ever had colon polyps? ☐Yes ☐No	
Have you ever had colon cancer? ☐Yes ☐No	
Any relatives w/ colon cancer/colon polyps? ☐Yes ☐No	Relationship? _____ Age of diagnosis? _____

Previous upper endoscopy for known Barrett's esophagus? ☐Yes ☐No	When?	Where?
On a daily medication for reflux, heartburn or Barrett's? ☐Yes ☐No	If yes, medication name:	

Hematologic:

☐Anemia
☐Bleeding disorder

Neurological:

☐Stroke/TIA
If so, when? _____
Continued weakness? ☐Yes ☐No
☐Seizures
If so, date of last episode? _____

Cardiovascular:

☐Chest Pain/Pressure/Heaviness
☐Irregular Heart Rhythm
☐High Blood Pressure
☐Congestive Heart Failure
☐ Aortic Valve Disease (stenosis or regurgitation)
☐Heart Valve Surgery
If so, when? _____

☐Heart Attack/Coronary Heart Disease
If so, when? _____
☐Heart Stents Placed
If so, when? _____
☐Heart Bypass
If so, when? _____
☐Defibrillator and/or Pacemaker
If so, what brand? _____

Genitourinary:

☐Kidney Disease/Failure
☐Insulin for Diabetes
☐PO Diabetes
☐Dialysis
If so, what kind? _____

Respiratory:

☐Sleep apnea
☐Shortness of breath
☐Asthma
☐COPD/Emphysema/ Chronic Bronchitis
☐ CPAP
☐ On Oxygen
If so, how many liters and when? _____

Hospitalization within the last month?	☐Yes ☐No	If yes, reason for hospitalization?
Previous problem(s) with anesthesia?	☐Yes ☐No	If yes, describe.
Organ transplant recipient?	☐Yes ☐No	If yes, what organ and when?
Received chemotherapy and/or radiation within the last month?	☐Yes ☐No	If yes, when?

Please list any current or prior medical problems that have not been listed above:	

Surgical History (check all that apply and provide date of surgery)			
☐Colon Surgery	Date:	☐Obesity Surgery	Date:
☐Hemorrhoid Surgery	Date:	☐Appendectomy	Date:
☐Hernia Surgery	Date:	☐Hysterectomy	Date:
☐Gastric Surgery	Date:	☐CABG/Heart Surgery	Date:
☐Liver Surgery	Date:	☐Spinal Surgery	Date:
☐Laparotomy	Date:	☐Other _____	Date:

Allergies: (check all that apply and describe reaction)		**Reaction to allergy:**
☐No known allergies ☐Codeine Sulfate ☐Versed ☐Morphine ☐Iodinated Contrast ☐Fentanyl Citrate	☐Penicillin ☐Demerol ☐Propofol ☐Latex ☐Adhesive Tape ☐Other _____	

Medications (prescription, OTC, herbals)

Name of drug	Strength/Frequency	Name of drug	Strength/Frequency
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

Disclaimer:

I agree, that these questions have been answered honestly and to the best of my knowledge. I understand that providing inaccurate information could result in complications during my procedure. I agree to contact the office and speak with a nurse if I have any health or medication changes prior to my scheduled procedure.

Patient Signature: _____ **Date:** _____

Please complete these forms in its entirety and return to our office. You will receive a call from one of our schedulers to schedule your colonoscopy, or office visit. Please allow 5-7 business days for an Open Access Scheduler to contact you. If you prefer to speak with an Open Access Scheduler, please call (864) 678-8191.

How to submit forms:

Visit our website: www.gastroassociates.com

Mail to:
Open Access Program
Gastroenterology Associates
125 Halton Road, Suite 200
Greenville, SC 29607

Fax to: (864)451-5187 or (864) 451-5169

Email to: openaccess2@gastroassociates.com