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. Please check your screening benefits to verify coverage.

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. We will submit all insurance claims on your behalf when all necessary information is 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
☐Change in bowel habits

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 with colon cancer/colon polyps? ☐Yes ☐No	Relationship? _____ Age of diagnosis? _____

On average, how often did you have a bowel movement in the past 3 months?
☐3+ times/day ☐2-3 times/day ☐1x/day ☐1-2 times/week ☐less than 1x/week

Have you used any form of laxative in the past 3 months? ☐Yes ☐No

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 their entirety and return them 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