Open Access Screening Colonoscopy Medical History Questionnaire

PARK GI GASTROENTEROLOGY
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Name _____ **DOB** _____ **Pharmacy (Location)** _____

Address _____ **City**_____ **State** _____ **Zip** _____

Phone _____ **Mobile Phone** _____ **Email** _____

Referring Provider _____ Why was a colonoscopy recommended? Screening ___GI Symptoms: _____

Do you smoke? ___Yes (How Much _____) ___No ___ Former Smoker ___ Smokeless Tobacco ___ Vape Products

Do you drink alcohol? ___ Yes (Type _____ How Much _____ How Often _____) ___ No

Have you ever had difficulty with anesthesia? ___ Yes ___ No Are you able to walk without help? ___Yes ___No

Do you have a Pacemaker? ___ Yes ___ No Do you have a Defibrillator? Yes ___ No ___ Are you on Dialysis? ___Yes ___ No

Height: _____ Weight: _____ List any Medication Allergies: _____

Do you take Aspirin ? ___ Yes ___ No Blood Thinners ___ Yes ___No Name: _____ **Dose** _____

Name	Dose	Name	Dose	Name	Dose

Place a check mark to the left of any medical condition you have been diagnosed with:

	Anemia		Deep Vein Thrombosis		COPD
	Asthma		Diabetes		Liver Disease/Cirrhosis
	Cancer (specify)		Hepatitis B__ Hepatitis C __		Sleep Apnea
	Colon polyps		High Blood Pressure		Other:
	Congestive Heart Failure		Crohn's Disease/Colitis		Other:
	Heart Disease/Heart Attack		Kidney Disease		Other:

Place a check mark to the left of any previous surgeries you've had. Use the "Other" section for any not listed.

			Heart Surgery (Bypass/CABG)		Tubal ligation
	Bariatric (Weight Loss) Surgery				Hysterectomy
	Other:		Other:		Other:

Fax this form to (919) 650-6422

For Office Use Only

___ Approved for Open Access ___ Needs Office Visit to Evaluate_____

Provider Signature _____ Date _____

Patient Scheduled: Date_____ Time_____