Katy Digestive Center, PLLC

PRE-COLONOSCOPY PATIENT QUESTIONNAIRE

INTRODUCTION

Colonoscopy is a relatively short and safe procedure. However, as with any medical procedures, complications are possible (for details, please read the included brochure "COLONOSCOPY"). To minimize the risk of unexpected events or possible complications, please read carefully and complete the questionnaire below. It is important that you answer all questions as accurately as possible. Answers to questions 9 and 10 will be updated at the time of colonoscopy by your physician. At that time, you will also be examined and you will have the opportunity to discuss any important issues with your physician.

PATIENT DEMOGRAPHIC INFORMATION

Full name_____Social Security Number: _____

Date of birth_____Age _____ Sex _____ Address_____ City_____ Zip Code _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Home Phone _____ Cell phone _____ E-mail address: _____

Patient Employer _____ Address: _____

Emergency contact: Name:_____ Relation to you _____ Phone _____

First and Last Name of Referring physician: _____ ❑ I do not have a referring physician

INSURANCE INFORMATION

❑ Check here if you do not have health insurance and you are willing to cover expenses by yourself.

Name of insurance _____ Your ID number_____

Address of primary insurance:_____Group number _____

Telephone: _____, Fax: _____

Name of insured person (if other than you): _____ Relation to you _____

Insured's billing address (if different from patient): _____

PATIENT HEALTH INFORMATION

Height: ____ft____ in Weight: _____lbs

GENERAL HISTORY

(Please circle the correct answer (YES or NO) and check all boxes with positive answers to the respective question)

1. Are you allergic to any medications ? YES NO **If YES**, list all medications: _____

2. Do you currently smoke ? YES NO If you smoked in the past, when did you quit

3. Do you drink alcohol ? YES NO **If YES**, for how many years: _____ Number drinks/day ____

Have you ever been diagnosed with colorectal cancer? YES NO **If YES**, when was the diagnosis made (date) _____

Did you have colonoscopy(s) performed after diagnosis of colorectal cancer? YES NO **If YES**, when was your last colonoscopy _____

4. Do you have a family history (first-degree relatives) of **colon cancer** ? YES NO **If YES**, check all the relatives with polyps and/or cancer:
   - ❑ Mother, at age _____ ❑ Father, at age _____
   - ❑ Brother, at age _____ ❑ Sister, at age _____
   - ❑ Child, at age _____

4a. Do you have a family member(s) with **colon polyps** removed? YES NO Explain: _____

PREVIOUS HISTORY OF COLONOSCOPIES AND ABDOMINAL DISEASES

5. Have you ever had a **full colonoscopy** with sedation ? YES NO

If YES, how many colonoscopies? _____

When did you have your last colonoscopy _____

If YES, did you have any complications including:

- ❑ abdominal pain
- ❑ fever
- ❑ nausea / vomiting
- ❑ bowel perforation
- ❑ abdominal gas / bloating
- ❑ rectal bleeding after the procedure
- ❑ other (describe) _____

6. Have you ever had **polyps removed** during colonoscopy ? YES NO

If YES, how many times _____

- Date of last colonoscopy _____
- How many polyps removed at the last colonoscopy _____

Additional comments:

7. Have you ever been diagnosed and treated for **any cancer of an abdominal organ** (including prostate, ovary, uterus, liver, gallbladder, pancreas, small bowel, stomach, and abdominal lymphoma) ? YES NO

If YES, which organ was involved _____

_____

_____

8. Have you had any of the **abdominal surgeries** listed below:

- ❑ Cholecystectomy (removal of the gallbladder)
- ❑ Hysterectomy (removal of the uterus)
- ❑ C-section
- ❑ Appendectomy
- ❑ Hernia repair
- ❑ Other not listed (please describe briefly) _____

MEDICATIONS YOU CURRENTLY TAKE AND PAST MEDICAL HISTORY

9. List **all** the medications you have been taking **within the last two weeks** (including the ones taken on "as needed" basis):

_____

10. Specifically, **within the last week** did you at least once take any of the following medications:

- ❑ Aspirin, Ibuprofen, Advil, Naprosyn, Voltaren, Aleve or similar anti-inflammatory medications
- ❑ Coumadin (Warfarin)
- ❑ Heparin
- ❑ Lovenox (Enoxaparin)
- ❑ Plavix (Clopidogrel)
- ❑ Ticlid (Ticlopidine)
- ❑ Pradaxa (Dabigatran)

11. Have you ever been treated for any of the following disorders:

Asthma	YES	NO	Loss of consciousness Irregular	YES	NO
Diabetes	YES	NO	heart beat Abnormalities in	YES	NO
Stroke	YES	NO	blood clotting	YES	NO
Heart attack	YES	NO	Crohn's disease or ulcerative colitis	YES	NO
Emphysema	YES	NO	Seizures	YES	NO
Sleep Apnea	YES	NO	Hypertension	YES	NO

PAST HISTORY OF HEART DISEASES

12. Have you ever had a heart or lung surgery?	YES	NO
13. Do you have a pacemaker?	YES	NO
14. Do you have an implanted defibrillator?	YES	NO
15. Do you have an artificial heart valve?	YES	NO
16. Have you ever had endocarditis?	YES	NO
17. Have you ever been given antibiotics before dental or surgical procedures?	YES	NO

Please, carefully review all your answers above. **If you are uncertain about some of the answers, leave the space blank or place a question mark. You will have the opportunity to clarify these issues later, during a short interview with a member of our staff.**

PHARMACY NAME .....

PHARMACY PHONE NUMBER....._____

PLEASE ATTACH A COPY OF YOUR PICTURE ID AND A COPY OF YOUR INSURANCE CARD

Now, please read carefully the statement below, and sign and date it at the designated space.

PATIENT STATEMENT

I have reviewed the above Pre-Colonoscopy Patient Questionnaire, and I have answered all the questions to the best of my knowledge. I understand that incomplete or false information may result in unexpected complications related to the colonoscopic procedure itself or to the conscious sedation. These complications, which may happen even with your excellent health, may include abdominal pain and bloating, bleeding, bowel perforation, and reaction to medications. I also understand and accept the fact that my colonoscopy may not be completed due to inadequate preparation of the colon, my reactions to the medications used for conscious sedation, or excessive risk for complications as decided by the performing physician before or during the procedure. In such case, I may choose to have another colonoscopy at different time, or to have barium enema – a radiological procedure (X-ray) during which a liquid contrast material is used to evaluate colon for presence of polyps and cancers. However, barium enema is generally less sensitive for detection of small polyps and masses than colonoscopy, may be uncomfortable, and does not allow removal of detected lesions. Finally, I may choose not to have any follow-up screening procedure and I understand the possible risks of such a decision.

_____ _____ _____

Patient's Signature Print Name Date

Now please choose the date for your colonoscopy. Please be advised that fulfilling your request may not always be possible.

My preferred time frame for the procedure is:

- ❑ As soon as possible
- ❑ Within a month
- ❑ Within few months
- ❑ I have no preference

My physician: ❑ Dr. Murtaza Arif

I have been seen by this physician in the past (circle one): YES NO

This physician performed my previous colonoscopy(s): YES NO

Dr. Murtaza Arif is Board Certified, highly trained and an experienced professional.

You have reached the end of the Questionnaire. Please make sure that you have signed and dated the Patient Statement on page 3. **Next, please put the PRE-COLONOSCOPY PATIENT QUESTIONNAIRE in a stamped envelope and mail it to us** at:

Katy Digestive Center, PLLC
1331 W. Grand Parkway N., Suite 350
Katy, TX 77493
Re: Open Access Colonoscopy

You may also **fax** the PRE-COLONOSCOPY PATIENT QUESTIONNAIRE to **832-437-2958**

The best way to contact you is: ❑ telephone call (#_____-_____-_____)

❑ e-mail (address-please print: _____)

We will contact you within 10 to 14 days after receiving the Questionnaire. At that time, we will discuss with you the preparation needed for the procedure, name of the physician who will perform your colonoscopy, date and time of the procedure as well as the location of the endoscopy suite.

Please expect 10 to 14 days from the time we receive this Questionnaire before we will contact you. **If we do not contact you within 14 days, please first check you Answering Machine or Voice Mail for message from us. If there is no message, please call us at 281-392-0425, option 1 for Dr. Arif.**

If you have any questions or additional information you would like to share with us at this time please write them in the space below.