MEDICAL QUESTIONNAIRE FOR SCREENING COLONOSCOPY

Today’s Date:______________
Name:______________________ Age:____ Date of Birth:_______
Sex:  M / F  Occupation:__________________________

The reasons for the colonoscopy are (check all that apply):
   Screening (age over 50) __________
   Family history of colon cancer __________
   Polyps removed at a previous colonoscopy __________
   Previous colorectal cancer __________
   Hidden blood found in stool __________
   Blood test abnormality __________
   Symptoms:  Rectal bleeding __________
               Change in bowel habits __________
               Constipation __________
               Diarrhea __________

Have you ever had a colonoscopy before? __________ If yes, please complete below:
   Circle any years when polyps were found & removed
   YEAR  PHYSICIAN  FACILITY  CITY & STATE
   (if outside metro Atlanta)

Have you ever had an upper endoscopy (EGD, gastroscopy)? ________________

List all prescription medications you are now taking (include doses). If you are not sure about name or dosage, please bring the medicine bottles with you to office consultation.
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

List all non-prescription medications you have taken within the past two weeks or take on a frequent basis. Include aspirin (with dose), ibuprofen, Advil, Motrin, Alleve, naproxyn, vitamin E, laxatives, suppositories, and enemas. Specify how often you take each of these.
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Do you use laxatives?_______ Which ones?__________________________ How often?___________

Circle any of the following blood-thinning medications that you may be taking: Coumadin (warfarin), Plavix, Aggrenox, Pletal. Who is the prescribing physician?
________________________________________________________________________
For what conditions are you taking this blood thinner?
________________________________________________________________________
List any **allergies to medicines**

If you have had a colonoscopy previously, did you have any problem with the bowel prep? __________ With the sedation? ____________ Any problems afterwards? __________

Do you have difficulty breathing (asthma, COPD, emphysema)? __________ Do you use supplemental oxygen? __________

Have you ever had a problem with a sedative or anesthesia? __________

Has anxiety been a major problem recently? __________

Are there any problems with your kidney function (renal failure)? __________

Have you had problems with low or high potassium or calcium in your blood? __________

Do you have an implantable defibrillator? __________ Do you have a pacemaker? __________

Have you been troubled by chest pain, chest pressure or smothering in the past year? __________ Have you ever had a heart attack? __________

Do you have atrial fibrillation? __________ Do you have any other abnormal heart rhythm? __________ Are you aware of any problem with the valves of your heart? __________

Do you smoke cigarettes? __________ How many per day? __________ For how many years? __________

If you no longer smoke, how much did you smoke, for how many years, and when did you stop? __________

Please circle the number of alcoholic beverages you typically consume in one week:
none 1 to 3 4 to 7 8 to 14 15 to 21 22 to 28 more than 28

If you no longer drink, how much did you drink, for how many years, and when did you stop? __________

Has either a parent, brother, sister, child or grandparent had cancer of colon or rectum? __________ If yes, what relationship and at what age was that person diagnosed? __________

Have parents or siblings had colon polyps? __________ Who? __________

Has either a parent, sibling or child had any of the following (indicate relationship):

<table>
<thead>
<tr>
<th>Condition</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer</td>
<td></td>
</tr>
<tr>
<td>Cirrhosis of liver</td>
<td></td>
</tr>
<tr>
<td>Crohn’s disease</td>
<td></td>
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<tr>
<td>Kidney cancer</td>
<td></td>
</tr>
<tr>
<td>Ovarian cancer</td>
<td></td>
</tr>
<tr>
<td>Pancreatic cancer</td>
<td></td>
</tr>
<tr>
<td>Sprue (celiac disease)</td>
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<tr>
<td>Stomach cancer</td>
<td></td>
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<tr>
<td>Ulcerative colitis</td>
<td></td>
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<tr>
<td>Uterus cancer</td>
<td></td>
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</tbody>
</table>

Please list all previous surgeries (include approximate dates):

______________________________________________________________________________________

Other than for surgeries, have you ever stayed overnight in a hospital? __________ If so, please give the medical conditions that were treated and approximate dates:

______________________________________________________________________________________

______________________________________________________________________________________

Have you ever been diagnosed with cancer? __________ If yes, please provide primary organ involved and date first diagnosed:

______________________________________________________________________________________
Please check any of the listed gastrointestinal problems that you have had. **Circle** those that are **active** at this time:

- Anal Fissure (tear)_____
- Anal itching or burning_____
- Anal pain_____
- Bleeding Hemorrhoids_____
- Protruding Hemorrhoids_____
- Rectal Bleeding_____
- Frequent abdominal pain_____
- Adhesions_____
- Bloating_____
- Bowel Obstruction_____
- Constipation_____
- Diarrhea lasting more than 1 week_____
- Diarrhea at least once per week_____
- Fecal Incontinence (accidental BMs)_____
- Seepage of stool_____
- Filling up easily_____
- Frequent nausea_____
- Frequent or recent vomiting_____
- Giardia or other parasites_____
- Lactose Intolerance_____
- Oil in stool_____
- Unintentional weight loss_____

My typical bowel pattern is:

(a) 1-2 per day_____
(b) 1 every other day_____
(c) 2-3 per week_____
(d) 1 per week_____
(e) 1 every 2 weeks_____
(f) 3 or more per day (give number)_____

Please circle those problems that have been present in the past year:

- Fatigue_____
- Weakness_____
- Poor appetite_____
- Unexplained fever_____
- Night sweats_____
- Malaise (just feel blah)_____
- H.I.V._____
- Glaucoma_____
- Double vision_____
- Major vision loss_____
- Hearing loss_____
- Hearing in ears_____
- Nasal congestion_____
- Sinus problems_____
- Diabetes_____
- High thyroid_____
- Low thyroid_____
- Goiter_____
- Tuberculosis_____

- Irritable Bowel Syndrome_____
- Diverticulosis_____
- Diverticulitis_____
- Diverticular hemorrhage_____
- Crohn’s Disease_____
- Ulcerative Colitis/Proctitis_____
- Cirrhosis_____
- Hepatitis B_____
- Hepatitis C_____
- Fatty Liver_____
- Jaundice_____
- Pancreatitis_____
- Other liver disorder (specify)_____
- Acid reflux_____
- Difficulty swallowing_____
- Esophageal stricture_____
- Esophagitis_____
- Food hanging up in chest_____
- Heartburn_____
- Hiatal hernia_____
- Regurgitation_____
- Schatzki’s Ring_____
- Duodenal ulcer_____
- Gastric ulcer_____
- Peptic ulcer_____
- Gallstones_____
- Gallbladder surgery_____

- Bronchitis_____
- Asthma_____
- Emphysema_____
- Chronic cough_____
- Blood clot in lung_____
- Coughing up blood_____
- Shortness of breath_____
- High blood pressure_____
- Low blood pressure_____
- Fainting_____
- Chest pain_____
- Angina_____
- Congestive heart failure_____
- Palpitations_____
- Abnormal heart rhythm_____
- Mitral valve prolapse_____
- Rheumatic heart disease_____
- Difficulty urinating_____
- Burning when urinating_____

3
Kidney Stones    Muscle weakness
Kidney failure    Seizures
Dialysis
Abdominal hernia
Anemia (low blood)
Low iron
Low platelets
Easy bleeding
Thalassemia
Blood clot in legs
Aneurysm
Stroke
TIA (transient ischemic attack)
Continuous weakness of a limb
Continuous loss of sensation of a limb
Multiple sclerosis
Frequent headaches (non-migraine)
Migraine headaches
Cluster headaches
Drug dependence

Muscle weakness
Awakening to urinate
Seizures
Blood in urine
Frequent numbness
Restless legs
Osteoarthritis
Rheumatoid arthritis
Other arthritis
Osteoporosis
Back pain
Neck pain
Fibromyalgia
Difficulty sleeping
Sleep apnea
Depression
Anxiety
Bipolar disorder
Hallucinations
Suicidal thoughts
Alcoholism

WOMEN ONLY:
Endometriosis
Heavy menstrual periods
Very painful menstrual periods
Ovarian cysts
Pain during intercourse
Pelvic pain

MEN ONLY:
Difficulty with erection
Mass in testicles
Pain in testicles
Prostate cancer
Prostate enlargement

If you think you have a significant medical problem that was not covered on this form, please list below: