**Express:** ☐

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# MEDICAL QUESTIONNAIRE FOR SCREENING COLONOSCOPY

** **Please view educational video →** http://www.asge.org/education-videos/colonvideo1.html **

Today's Date:_____
Name:_____Age:_____Date of Birth:_____
Sex: M / F **Contact - Phone number**:_____Height/Weight:_____
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?_____
Circle any years when polyps were found & removed

If yes, please complete below:

| 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):

| | |
|---|---|
| Breast cancer_____ | Pancreatic cancer____ |
| Cirrhosis of liver_____ | Sprue (celiac disease)_____ |
| Crohn's disease_____ | Stomach cancer_____ |
| Kidney cancer_____ | Ulcerative colitis_____ |
| Ovarian cancer_____ | Uterus cancer_____ |

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 Intolerence_____
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)_____

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_____

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
Ringing in ears
Nasal congestion
Sinus problems
Diabetes
High thyroid
Low thyroid
Goiter
Tuberculosis

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

Kidney Stones
Kidney failure
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 weaknessAwakening to urinate
SeizuresBlood 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

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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

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

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