

## COLONOSCOPY History Form

NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_  
(REQUIRED)

Primary Care Physician \_\_\_\_\_ Referring Provider \_\_\_\_\_

Is a Language Interpreter needed? \_\_\_\_\_ What Language? \_\_\_\_\_

Do you have any Physical Limitations? \_\_\_\_\_ Use a wheelchair? \_\_\_\_\_

Anesthesia	YES	NO
Do you use home oxygen or have uncontrolled Asthma?		
Do you or anyone in your family have severe/life threatening problems with anesthesia such as history of malignant hyperthermia?		
Cardiac/Vascular		
Do you have a Pacemaker or a Defibrillator in place?		
Do you currently suffer from Angina?		
Are you diagnosed with Congestive heart failure (CHF)?		
Do you or anyone in your family have problems with clotting or blood/bleeding disorders (i.e. Hemophilia, Von Willebrand Disease)?		
Have you had a stroke or heart attack in the past 6 months? <i>If YES, you need to get cardiac clearance from your cardiologist (in writing) for us to proceed.</i>		
Cardiologist Name: _____		
Other		
Do you take a blood thinner (Coumadin, Plavix, Lovenox or Aggrenox)?		
Are you a Diabetic? If so what medication do you use?		
Any Allergies (including Latex)?		
Have you tested positive for MRSA? If so what body part?		
Do you have a history of Cirrhosis?		
Any contact with anyone who has a Communicable Disease within the last 30 days (chicken pox)?		
Do you have any kidney problems?		
Are you on dialysis?		

**Please state PATIENT, MOTHER, FATHER, SISTER, BROTHER, CHILD or NONE**

### Bowel/Colon Problems

Colon Cancer \_\_\_\_\_ Irritable Bowel Syndrome \_\_\_\_\_  
 Crohn's Disease \_\_\_\_\_ Ulcerative Colitis \_\_\_\_\_  
 Bowel Changes (*patient only*) \_\_\_\_\_ Polyps \_\_\_\_\_  
 Rectal Bleeding (*patient only*) \_\_\_\_\_

**\*\*Please note that certain medical conditions require a hospital setting for procedures.**

Last Colonoscopy (*year*) \_\_\_\_\_ Last Flexible Sigmoidoscopy (*year*) \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Hospital phone call preference: AM PM EVE

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

✿ FOR OFFICE USE ONLY / Do Not Fill In ✿					
Date _____	Time _____	Arrival _____	PAT Date _____	Home / Work / Cell	ST. JOE'S DH
Bueno	Gulur	Nagri	Scherer		