



**DIRECT ACCESS SCREENING COLONOSCOPY EVALUATION FORM**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

I am being referred to your office for a screening colonoscopy as part of my over 50 complete physical. (Please answer yes or no)  Yes  No

I have a: (Please answer yes or no)

- Personal history** of colon polyp:  Yes  No
- Personal history** of colon cancer:  Yes  No
- Family history** of colon polyps:  Yes  No
- Family history** of colon cancer:  Yes  No

If there is a family history, please indicate relationship (s) of family member (s): \_\_\_\_\_

Date of last exam by: Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Have you ever been told you require antibiotics prior to any surgery?  Yes  No

Have you ever had an artificial joint replacement procedure performed?  Yes  No

Other information that you wish to include: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Gastrointestinal Problems** (please check all that apply)

<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Abnormal liver blood tests	<input type="checkbox"/> Black, tarry stools
<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Constipation	<input type="checkbox"/> Vomiting blood
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Incontinence of stool
<input type="checkbox"/> Nausea or vomiting	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Regurgitation
<input type="checkbox"/> Bloating	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> History of hepatitis Type _____
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Abnormal abdominal CT scan or ultrasound

**Have you ever had any of the following tests?** (If yes, circle all that apply and provide requested information)

	Date	Physician	Location or Facility
Upper GI Series	_____	_____	_____
Upper Endoscopy	_____	_____	_____
Barium Enema	_____	_____	_____
Flexible Sigmoidoscopy	_____	_____	_____
Colonoscopy	_____	_____	_____
Ultrasound (abdomen)	_____	_____	_____

**PAST MEDICAL ILLNESSES** (Please check any medical conditions you have been diagnosed with)

**Gastrointestinal**

<input type="checkbox"/> Heartburn/GERD	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Anal Fistula
<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Fatty Liver
<input type="checkbox"/> Gastritis	<input type="checkbox"/> Irritable bowel (IBS)	<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> H. Pylori	<input type="checkbox"/> Spastic Colitis	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Cirrhosis
<input type="checkbox"/> Ulcer	<input type="checkbox"/> Lactose Intolerance	<input type="checkbox"/> Hemorrhoids	
<input type="checkbox"/> Celiac Disease	<input type="checkbox"/> Diverticulosis/itis	<input type="checkbox"/> Anal Fissure	

**Cardiovascular**

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Angina	<input type="checkbox"/> PVC's (extra heart beats)		

**Pulmonary**

<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Sarcoidosis	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Emphysema (COPD)	<input type="checkbox"/> Pulmonary Embolism	<input type="checkbox"/> Lung Cancer	

**Neuropsychiatric**

<input type="checkbox"/> Stroke	<input type="checkbox"/> Migraines	<input type="checkbox"/> Dementia	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> TIA (mini-stroke)	<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> Depression	<input type="checkbox"/> ADHD
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Anxiety	
<input type="checkbox"/> Seizures	<input type="checkbox"/> Myasthenia gravis	<input type="checkbox"/> Bipolar Disorder	

**Hematologic**

<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Hodgkin's Disease	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Hemochromatosis	<input type="checkbox"/> Lymphoma	<input type="checkbox"/> Myelodysplasia

**Endocrine**

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Goiter	<input type="checkbox"/> Pituitary Problem
<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Thyroid Nodule	<input type="checkbox"/> Thyroid Cancer	<input type="checkbox"/> Adrenal Problem

**Genitourinary**

<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Urinary Tract Infections	<input type="checkbox"/> Ovarian (Cyst(s))	<input type="checkbox"/> Abnormal PAP smears
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Bladder Incontinence	<input type="checkbox"/> Ovarian Cancer	<input type="checkbox"/> Cone Biopsy/LEEP
<input type="checkbox"/> Kidney Tumors/Cysts	<input type="checkbox"/> Prostate Hypertrophy	<input type="checkbox"/> Uterine Fibroids	<input type="checkbox"/> Cervical Cancer
<input type="checkbox"/> Bladder Cancer	<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Uterine Cancer	<input type="checkbox"/> Endometriosis

**Oncologic**

<input type="checkbox"/> Any other surgical tumors not mentioned
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**Surgical History** (list all surgeries and procedures)

**Date**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Allergies or Reactions to Medications to Include Over-the Counter** (please list all)

I do not have any allergies or reactions to medications to include over-the counter

**Are you allergic to latex?** (check yes or no)  Yes  No

**Are you allergic to Iodine or IV contrast dye?** (check yes or no)  Yes  No

**Please review the following statements and check, where applicable**

<input type="checkbox"/> I have had prior difficulties with anesthesia	<input type="checkbox"/> I have a pacemaker
<input type="checkbox"/> I have sleep apnea	<input type="checkbox"/> I Use a CPAP device
<input type="checkbox"/> I have a defibrillator	<input type="checkbox"/> I have a cardiac stent
<input type="checkbox"/> I am on a blood thinner	<input type="checkbox"/> I have an artificial valve
<input type="checkbox"/> I take non-steroidal medications (ie. Motrin, Aleve, Advil, etc.)	<input type="checkbox"/> I have had a blood transfusion

**Medications** (list all prescription and “over-the-counter” medications)

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**FAMILY HISTORY**

Do any of your family members have these diseases? (If so, indicate family member)

	<u>Relationship</u>		<u>Relationship</u>
Colon Cancer	_____	Uterine Cancer	_____
Crohn’s Disease	_____	Kidney Cancer	_____
Ulcerative Colitis	_____	Breast Cancer	_____
Celiac Disease	_____	Thyroid Cancer	_____
Stomach Cancer	_____	Liver Cancer	_____
Pancreatic Cancer	_____	Colon Polyps	_____
Ovarian Cancer	_____		

**I am in good health and wish to schedule this colonoscopy without a preliminary visit to the office?** (Answer yes or no)  Yes  No

**Through my signature affixed below, I acknowledge that the above information has been provided to the best of my knowledge**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**Grey box for physician use only**

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