COOKEVILLE REGIONAL
MEDICAL CENTER
CRMG

Open Access Colonoscopy Questionnaire

CRMG Gastroenterology Associates has developed a program which allows healthy individuals to schedule screening colonoscopy without the need for an office visit before the procedure. If your physician has suggested that you have a colonoscopy you may qualify for this program. Of course, not all patients will be able to safely undergo colonoscopy without a more detailed evaluation of their health history and their risks for the procedure. If that is the case for you, we will help you schedule an office visit so that a physician can review your medical history, assess your current condition, and determine how to best meet your health needs. ***Someone from our office will contact you within 10 days***

NAME:_____ DATE OF BIRTH: _____ ❑ MALE ❑ FEMALE

Pharmacy Name:_____

1. How old are you today? _____

2. Have you had a colonoscopy in the past? ❑ YES ❑ NO
   a. If the answer is yes, when and where?
   _____
   b. What were the results?
   ❑ Polyp(s) ❑ Cancer ❑ Crohn's Disease
   ❑ Ulcerative Colitis ❑ Other?

3. Why did your doctor suggest a colonoscopy at this time?
   _____
   a. If colonoscopy was recommended because of family history of colon cancer or polyps, which relative had cancer or polyps and how old were they when diagnosed?
   _____

4. Do you have any gastrointestinal symptoms such as abdominal pain, bleeding (red blood or tarry black stool), weight loss, heartburn (take chronic anti-acid medication), change in bowel habits, diarrhea, constipation, or anemia? ❑ YES ❑ NO
   If yes, please explain: _____

5. Do you smoke? ❑ YES ❑ NO
   How often and how much? _____

6. Do you drink alcohol? ❑ YES ❑ NO
   How often and how much? _____

7. Do you have any DRUG allergies? ❑ YES ❑ NO
   If yes, to what? _____

8. Do you take any blood thinners other than aspirin?
   ❑ YES ❑ NO

9. List all medications that you take including herbals and over the counter medications:
   _____ _____
   _____ _____
   _____ _____
   _____ _____

10. Have you had difficulty with anesthesia other than nausea?
    ❑ YES ❑ NO

11. Have you had gastric bypass or other obesity surgery?
    ❑ YES ❑ NO

12. Are you able to walk without help? ❑ YES ❑ NO

13. Current height? _____ Current weight? _____

14. Do you take antibiotics prior to dental procedures?
    ❑ YES ❑ NO

15. Do you need antibiotics prior to procedures due to joint replacements?
    ❑ YES ❑ NO

DO YOU CURRENTLY OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

❑ YES ❑ NO a. ulcerative colitis or Crohn's disease

❑ YES ❑ NO b. heart attack, irregular heartbeat, coronary artery bypass or stent placement, stroke, seizure, fainting spells, or congestive heart failure

❑ YES ❑ NO c. renal failure or dialysis

❑ YES ❑ NO d. respiratory problems (COPD, emphysema, home oxygen, asthma or sleep apnea)

❑ YES ❑ NO e. diabetes

❑ YES ❑ NO f. defibrillator, pacemaker, or artificial heart valve

❑ YES ❑ NO g. organ transplant other than cornea

❑ YES ❑ NO h. anemia

NURSE SIGNATURE:_____

DATE: _____