

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 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) _____

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 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:

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