

Direct Access Colonoscopy Appointment Request Form

Fill out the form below to provide us with information to book your screening colonoscopy. Please note: Our team will review your submission. If you are eligible, your colonoscopy will be scheduled without the need for an in-office consultation. However, some responses may require an in-office consultation prior to scheduling your procedure.

Anything with * will require an answer to continue

First Name* _____

Last Name* _____

Phone Number* _____

Email Address* _____

Date of Birth (MM/DD/YYYY) * _____

What is your height in feet and inches? * _____

What is your weight in pounds? * _____

Do you require an interpreter? *

Yes _____

No _____

Do you have any physical limitations that would require assistance with ambulation? *

Yes _____

No _____

Allergies

Do you have any drug allergies? *

Yes/ Explain _____

No _____

Do you have any food allergies? *

Yes/ Explain (List) _____

No _____

Conditions and Procedures

Have you ever had a colonoscopy? *

Yes _____

No _____

If yes,

Date of colonoscopy? (MM/DD/YYYY): _____

Facility: _____

Provider: _____

Do you have a history of severe constipation or inadequate prep for a previous colonoscopy? *

Yes _____

No _____

Have you had a diagnosis of polyps or cancer in your colon? *

Yes, Polyps _____

Yes, Cancer _____

No _____

Unsure _____

Do you have a family history of colon cancer, ulcerative colitis or Crohn's disease? *

Yes _____

No _____

Unsure _____

Do you have any digestive issues such as abdominal pain, rectal bleeding, unintentional weight loss, diarrhea, constipation, anemia, colitis or Crohn's disease? *

Yes _____

No _____

Medical History: Have you had any of the following?

Have you ever seen a cardiologist? *

Yes _____

No _____

If yes,

Name of Cardiologist _____

Date of Last Visit _____

Reason for Visit _____

Heart attack, irregular heartbeat, coronary artery bypass or stent placement, stroke, fainting spells, congestive heart failure, aneurysm or uncontrolled hypertension? *

Yes _____

No _____

Defibrillator, pacemaker, or artificial heart valve? *

Yes _____

No _____

Breathing problems such as COPD, emphysema, asthma or obstructive sleep apnea, or use home oxygen or CPAP? *

Yes _____

No _____

Date of last rescue inhaler use? (MM/DD/YYYY) _____

Are you able to walk up a flight of steps without shortness of breath? *

Yes _____

No _____

Do you get short of breath when you lie flat? *

Yes _____

No _____

Have you been hospitalized in the last 30 days? *

Yes _____

No _____

Have you been diagnosed with cancer? *

Yes (list) _____

No _____

Kidney problems, renal failure, or are you on any form of dialysis? *

Yes _____

No _____

Insulin- dependent diabetes? *

Yes _____

No _____

Organ transplant or have you been evaluated for an organ transplant? *

Yes _____

No _____

History of seizures? *

Yes _____

No _____

Date of last seizure? _____

Name of Neurologist? _____

Seizure medications? _____

History of concussion or head injury? *

Yes _____

No _____

Do you have any blood or bleeding disorders? *

Yes _____

No _____

Are you pregnant or possibly pregnant? *

Yes _____

No _____

Have you had any issues with anesthesia in the past? *

Yes (list/explain) _____

No _____

Have you been told you have a difficult airway or issues with anesthesia? *

Yes _____

No _____

Has anyone in your family ever had a problem with anesthesia? *

Yes _____

No _____

Have you had any **surgery**? *

Yes (list with dates) _____

No _____

Medications

Do you take any blood thinners other than aspirin (Eliquis/Apixaban, Coumadin/Warfarin, Xarelto/Rivaroxaban, Plavix/Clopidogrel, Pradaxa/Dabigatran etc.)? *

Yes _____

No _____

Please List all prescription medications, vitamins, and herbal supplements you are currently taking. *

Name of medicine, dose, and frequency
