Express Scheduling for Screening Colonoscopy

Dear Patient:

Thank you for choosing Woodholme Gastroenterology Associates, P.A. and our express scheduling program. You have 2 options. You can call us and we will complete the form over the phone. Or you can complete the attached form and fax or mail it to our office and we will call you to discuss time and preparation. If you fax or mail your form to us, please indicate which physician and location you would like to go to.

Thank you. We look forward to hearing from you.

Physicians:
Edward J Wolf, M.D.
Todd Heller, M.D.
Loc Le, M.D.
Edward D. Zimmerman, M.D.
Lila Tarmin, M.D.
Michael S. Siuta, M.D.
Ernest Tsao, M.D.
Steven H. Epstein, M.D.
Eric B. Blum, M.D.
Keno Onwueme, M.D.
Elliott Schwarzenberger, M.D.
Woodholme Gastroenterology Associates
SCREENING COLONOSCOPY QUESTIONNAIRE

Name: ___________________________ DOB: ___________________________ Date: ___________________________

Date of Procedure: ___________________________ Location: ECB_____ EQS _________

Have you experienced any of the following symptoms recently or as an ongoing problem? (Please indicate with a Y or N)

_____ rectal bleeding
_____ diarrhea
_____ constipation
_____ abdominal pain
_____ change in bowel habits; specify: ___________________________

_____ family or personal history of colon cancer or polyps (relation and age at diagnosis): ___________________________

_____ difficult or painful swallowing
_____ uncontrolled heartburn
_____ nausea or vomiting
_____ unexplained weight loss
_____ anemia (low blood count)
_____ black stools
_____ heme positive stools (positive stool cards/microscopic blood in stool)

Have you ever had an allergic reaction to a medication or to latex? If so, indicate the medicine and the type of reaction: ___________________________

Do you require antibiotics before dental procedures, for i.e. Prosthetic heart valve or valvular abnormality, previous endocarditis, pulmonary shunt? __________________________

MEDICATIONS: (please list the name, dosage and frequency of each medicine – include over the counter, remind about stopping diet pills 14 days in advance):

________________________________________________________________________

________________________________________________________________________

Medical History: (please indicate with a Y or N)

_____ on home oxygen (COPD/emphysema)
_____ previous heart attack or heart problems
_____ taking blood thinners/anticoagulants
_____ kidney problems
_____ diabetes
_____ chronic lung disease
_____ sleep apnea, use of CPAP
_____ on multiple inhalers
_____ high blood pressure/or on diuretics
_____ Other ___________________________