EXPERIENCE & EXPERTISE MATTER

Charles E. Allen, MD, Scott A. Clark, MD, Sheraj Jacob, MD,
Vinayasekhara M. Reddy, MD, Namita Pareek, MD,
John L. Kalarickal, MD, Neeraj K. Sharma, MD,
Ankur Sheth, MD FACG, & Andrew Lake, MD

770-536-8109

www.gastrogainesville.com

Direct Access Colonoscopy Qualification Questionnaire

Please return this completed form to our office. Once the form is received it will be assigned to one of our Board-Certified Gastroenterologists for review. If no medical concerns are identified you will be contacted to set-up a Direct Access Colonoscopy.

PLEASE FAX TO DIRECT ACCESS COLONOSCOPY AT 678-997-2128

Today's Date: ________________

Patient Name: ____ **Age:** ______________ **Sex:** □ Female □ Male

Date of Birth: _________________________ **Email Address:**____

Address: ________________________________ **City:** _________________ **State:** ________ **Zip Code:**________

Home: (______)________-__________ **Work**: (______)________-__________ **Cell:** (______)________-________

Preferred Method of Contact: □ Home Phone □ Work Phone □ Mobile / Cell Phone

Height: ______ Feet **Weight:** _______ lbs. **Occupation:** ____

Primary Care Physician: ____________________________ **Referring Physician**:___________________________

Primary Insurance:_______________________________ **Subscriber ID**:______________________________

Secondary Insurance:_____________________________ **Subscriber ID**:______________________________

Preferred Pharmacy:____

Pharmacy Address: ___________________________ **City:** _______________ **State:** _______ **Zip Code:**________

Provider Request: □ Dr. Allen □ Dr. Clark □ Dr. Jacob □ Dr. Reddy □ Dr. Kalarickal □ Dr. Pareek □ Dr. Sharma □ Dr. Sheth □ Dr. Lake □ First Available

Reason for Colonoscopy (Select all that apply):

□ Screening (age over 50)
□ Previous Colorectal Cancer
□ Positive stool test for blood
□ Family History of Colon Cancer
□ Polyps removed previously
□ Other, if so please specify:

Have you had a colonoscopy previously? □ Yes □ No

If yes, please provide the following details:

Procedure Year:	
Performing Physician:	
Facility:	
City, State:	
Procedure Findings:	

Did you have any problems with the bowel prep? □ Yes □ No

If yes, please specify the problems you experienced with the bowel prep:

Check any gastrointestinal symptoms that you have experienced in the past year:

□ Frequent abdominal pain □ Constipation □ Diarrhea lasting more than 1 week

□ Black Stools □ Rectal Bleeding □ Frequent nausea or vomiting

□ None

Check any general medical issues that you have experienced in the past year:

□ Diabetes □ High thyroid □ Low thyroid □ Asthma

□ COPD □ Emphysema □ Home oxygen □ High blood pressure

□ High cholesterol □ Congestive heart failure □ Abnormal heart rhythm □ Heart valve problems

□ Heart attack □ Chest pain / chest pressure □ Pacemaker or defibrillator □ Kidney Failure

□ Dialysis □ Anemia (low blood) □ Blood clot in legs □ Aneurysm

□ Stroke □ Sleep apnea □ TIA (transient ischemic attack) □ None

Have you recently experienced or are you currently experiencing any of the following symptoms:

Night sweats? □ Yes □ No Persistent cough for 3 or more weeks? □ Yes □ No

Loss of appetite? □ Yes □ No Bloody Sputum? □ Yes □ No

Unexplained weight loss? □ Yes □ No Fever? □ Yes □ No

Anorexia? □ Yes □ No

How many stools do you have on a daily basis? ____

Have you ever been diagnosed with cancer? □ Yes □ No

If yes, please provide primary organ affected and date of first diagnosis: ____________________________

Please list any other medical problems not mentioned above: ____________________________

____

Has either a parent, brother, sister, child, or grandparent had cancer of colon or rectum?

What relationship and what age was that person diagnosed with cancer? ____________________________

Have any relatives had colon polyps? □ Yes □ No

If yes, please list relationship: ____

Have any relatives had any of the following?

	Not Applicable	Parent	Grandparent	Child	Aunt / Uncle	Cousin
Breast Cancer	◯	◯	◯	◯	◯	◯
Cirrhosis of liver	◯	◯	◯	◯	◯	◯
Crohn’s disease	◯	◯	◯	◯	◯	◯
Kidney Cancer	◯	◯	◯	◯	◯	◯
Ovarian Cancer	◯	◯	◯	◯	◯	◯
Pancreatic Cancer	◯	◯	◯	◯	◯	◯
Sprue (Celiac Disease)	◯	◯	◯	◯	◯	◯
Stomach cancer	◯	◯	◯	◯	◯	◯
Ulcerative colitis	◯	◯	◯	◯	◯	◯
Uterus cancer	◯	◯	◯	◯	◯	◯

Have you had any problems with sedatives or anesthesia in the past? □ Yes □ No

If yes please specify the problems you experienced with sedatives or anesthesia:

____

Please list all surgeries you've had in the past, with approximate dates: ___________________

____

If you've had to stay in the hospital overnight for anything besides surgeries, please list the medical conditions that were treated and give the approximate dates: ___________________

____

List all prescription medications you are taking now, and give doses: _____________________

____

List all non-prescription medication you have taken in the last few weeks, or that you take frequently. Include pain-killers, vitamins, laxatives, and how often you take each:

____

Please list any blood thinning medication that you are taking: (*Examples include Coumadin (Warfarin), Plavix, Aggrenox, Pletal)* Include the conditions that you are taking this medication for:

____

List any allergies to medication:

____

Do you smoke cigarettes? □ Yes □ No **How many per day?____ How many years?____**

How many alcoholic beverages you usually drink in a week:

☐ None ☐ 1-3 ☐ 4-7 ☐ 8-14 ☐ 15-21 ☐ More than 21

If you have anything to add that wasn't included in this form, please describe below:

____

____

I declare that the information I have given on this form is to the best of my knowledge, true and complete.

Patient Name: ____ Date:___________________________

Patient Signature:____ Date:____________________________

Thank you for completing the Direct Access Colonoscopy Questionnaire. You will be contacted within 10 business days regarding the physician's recommendations. If you have not heard from our office within this time frame, please contact our Care Coordinators at 678-696-8966.

Thank you for choosing Gastroenterology Associates of Gainesville P.C.

Recommendations: **For internal use only**

☐ Approved for Direct Access Colonoscopy at GEC/BEC with the following prep:

☐ MoviPrep ☐ Suprep ☐ Trilyte ☐ Gatorade ☐ Clenpiq ☐ Constipation ☐ Split

OR

☐ *Consultation appointment requested due to patient's* ______________________________________.

Reviewing Physician Name: ____

Reviewing Physician Signature: ____ *Date:*___________________