GASTRO HEALTH

COLORECTAL CANCER SCREENING CLINIC

NAME: _____DATE OF BIRTH:_____

AGE: _____ SSN#: _____ ADDRESS: _____

HOME PH: (____) _____ - _____ CELL PH: (____) _____ - _____ WORK PH: (____) _____ - _____

PLEASE LIST THE PHONE NUMBER(S) TO REACH YOU DURING BUSINESS HOURS

If you have a preference of a specific GI physician, please circle that provider's name:

Dr. Jayde Kurland Dr. Mark Leifer Dr. Robert Neidich Dr. Sheena Patel
Dr. Scott Rinesmith Dr. Tariq Sheikh Dr. Howard Solomon

Please complete this form by circling YES or NO in the right hand column and mail back for your physician to review. Our office will call you to schedule the procedure after it is reviewed

1. Do you have any heart problems? Ex. congestive heart failure, atrial fibrillation Have you ever had a heart attack? Have you ever had heart surgery? Ex. Open heart, stent(s), artificial valve pacemaker or internal defibrillator When? _____ If yes, please explain _____ Who is your cardiologist? _____	YES YES YES	NO NO NO
2. Do you take medication for high blood pressure or heart disease? If so, who is the prescribing doctor? _____	YES	NO
3. Do you have any kidney problems? _____ Are you currently on dialysis?	YES YES	NO NO
4. Have you ever had a stroke? If so, when? _____Any impairment from it? _____	YES	NO
5. Do you take any blood thinners? Ex. Plavix (clopidogrel), Pletal (cilostazol), Effient (prasugril), Brilinta (ticagrelor), Coumadin (warfarin), Pradaxa (dabigatran), Xarelto (rivaroxaban), Eliquis (apixaban), Lovenox, Savaysa (edoxaban), Aspirin If yes, why? _____ Who is your prescribing doctor? _____	YES	NO
6. Do you have any respiratory problems? Ex. tuberculosis, emphysema, COPD, Asthma If yes, please explain _____	YES	NO
7. Have you ever been diagnosed with sleep apnea? If yes, do you use a C-Pap/Bi-Pap machine? _____	YES	NO
8. Have you ever had any serious problems with Anesthesia? Ex. Hard to intubate, stopped breathing, dangerously high/low blood pressure, injuries to your nose, neck or back If yes, please explain _____	YES	NO
9. Do you have any other health problems or changes in your health status? If yes, please explain _____	YES	NO
10. Have you been hospitalized in the past 30 days? If so, why? _____	YES	NO
11. Do you have a family history of colon cancer? If yes, who _____	YES	NO
12. Do you (the patient) live in a nursing home / assisted living facility?	YES	NO
13. Have you had a previous colonoscopy? IF YES, when? _____ where? _____	YES	NO
14. What is your approximate weight? _____lbs. and height?_____		
15. Who is your family physician? _____		

PLEASE COMPLETE MEDICATION LIST AND INSURANCE INFORMATION ON BACK

OFFICE USE ONLY ** OFFICE USE ONLY ** OFFICE USE ONLY

Appt Date/Time: _____@_____ Location: _____Prep: _____
BMI:_____ Additional Information:

NAME:	DOB:
DATE:	
PLEASE LIST ALL CURRENT MEDICATIONS, OVER THE COUNTER DRUGS, HERBAL SUPPLEMENTS AND VITAMINS BELOW	
IF YOU ARE NOT TAKING ANY OF THE ABOVE, PLEASE CIRCLE: NONE	
EXAMPLE: NEXIUM	***40mg 1 tab once daily***
MEDICATION	**DOSAGE**

PLEASE LIST ALL ALLERGIES BELOW:	
IF YOU DO NOT HAVE ANY KNOWN ALLERGIES, PLEASE CIRCLE: NONE	
EXAMPLE: PENICILLIN	***HIVES***
ALLERGY TO	**REACTION**

PLEASE PROVIDE THE FOLLOWING INSURANCE INFORMATION:

***1st Insurance** _____ Holder _____ DOB: _____ SSN: _____
Policy/ID# _____ Group # _____ Employer _____
Claims Address _____
Benefit/Eligibility/Provider Service Phone #: _____

***2nd Insurance** _____ Holder _____ DOB: _____ SSN: _____
Policy/ID# _____ Group # _____ Employer _____
Claims Address _____
Benefit/Eligibility/Provider Service Phone #: _____

Patient Employer (if different than Ins. Holder): _____

*** PLEASE PROVIDE A COPY OF YOUR INSURANCE CARDS – FRONT AND BACK**