Request for Screening Colonoscopy/EGD

(Circle procedure you are requesting above)

First name:	Last Name:
DOB: Age:	Family or Referring Dr. and phone:
Address:	City: Zip:
Home phone:	Cell phone:
Pharmacy name/phone:	Email:

Which doctor are you being referred to? ☐ Dr.Stecevic ☐ Dr.Batke ☐ Dr. Reddy ☐ No Preference

Primary insurance	Subscriber name/DOB
Contract #	Group #
Secondary insurance	Subscriber name/DOB
Contract #	Group #

Please send a copy of the front and back of your Driver's License and Insurance Cards.

This is ☐ my first colonoscopy ☐ my second colonoscopy ☐ I had >2 colonoscopies in the past

My last colonoscopy was in _____ (year) at _____ (Hospital) done by Dr. _____

How much do you weigh? _____ lbs How tall are you? _____ ft _____in

Did you ever have problems with anesthesia during a surgical procedure?
☐ I never had anesthesia before ☐ No ☐ Yes _____ (please explain)

Do you have sleep apnea?
☐ No ☐ Yes, and I use a CPAP machine ☐ Yes, but I do not use a CPAP machine

Are you taking blood thinners?
☐ No ☐ Baby aspirin ☐ Full dose aspirin ☐ Plavix ☐ Prasugrel
☐ Coumadin ☐ Pradaxa ☐ Xarelto ☐ Lovenox ☐ Effient

☐ I never had colon polyps **☐ I had colon polyps removed in _____ (year)**

☐ Nobody in my family had colon cancer **☐ These relatives had colon cancer:**

☐ Nobody in my family had colon polyps **☐ These relatives had colon polyps:**

Allergies:

Current Medications and Vitamins/supplements:

Do you have any of the following diseases? ☐ Other: _____

☐ Diabetes	☐ Heart disease	☐ High blood pressure	☐ High cholesterol
☐ Atrial fibrillation	☐ Heart failure	☐ Endocarditis	☐ Stroke
☐ COPD	☐ Asthma	☐ Recent infection	☐ Kidney disease
☐ GERD / Reflux	☐ Barrett's esophagus	☐ Diverticulosis	☐ Abnormal liver tests
☐ Cancer	☐ Crohn's disease	☐ Ulcerative colitis	☐ Irritable bowel

What surgeries did you have in the past? ☐ Stents put in the heart in year _____

☐ Gallbladder removed	☐ Hysterectomy	☐ Prostatectomy	☐ Colon resection
☐ Valve replacement	☐ CABG/ Heart bypass	☐ AICD / defibrillator	☐ Other:

Are you CURRENTLY experiencing any of these symptoms?

☐ Diarrhea	☐ Heartburn	☐ Palpitations	☐ Abdominal pain
☐ Constipation	☐ Choking on food	☐ Shortness of breath	☐ Bloating
☐ Blood in stool	☐ Trouble swallowing	☐ Chest pain	☐ Unexplained Weight loss
☐ Change in bowel habits	☐ Food getting stuck	☐ Seizures	

If any are checked, please provide more information in the space provided.

Do you smoke? ☐ No ☐ Yes

How often do you consume alcohol?