

Please circle any of the below that apply to you:
If any apply you will need to see one of our physician's prior to
arranging an exam.

1. Heart Attack less than 6 months ago
2. Mechanical Heart Valve
3. Defibrillator patients need to be done @ PMC
(Pacemaker patients ok for YCEC)
4. Dialysis
5. Sleep Apnea on CPAP with BMI greater than 45
6. Patients on Coumadin or Lovenox
7. Patients' unable to walk up one flight of stairs
8. Recently Diagnosed with Diverticulitis requiring antibiotics
9. Age greater than 80

Patients Name _____

Date of Birth _____

What is the reason for scheduling your Colonoscopy today?

- Screening (No prior colonoscopy for 10 years)
- Previous history of colon polyps.
- Family history of colon polyps or colon cancer.

Please list any active medical problems. _____

Please list all medications (include over the counter products)

Do you take any of these blood thinning medications? Please circle any of the ones you take daily.
Coumadin Aspirin Lovenox Pradaxa Plavix Trental

Yes No Do you have bleeding problems? _____

Yes No Do you have any allergies to medications or eggs? Please list _____

Please circle Yes or No to answer the following medical history questions.

Heart Disease

Yes No Coronary Artery Disease / chest pain / heart attack / stents

Yes No High Blood Pressure

Yes No Congestive Heart Failure

Yes No Valvular Heart Disease / Artificial Heart Valve / Recent Heart Surgery

Yes No Do you have an internal pacemaker or defibrillator

Lung Disease

Yes No Emphysema, COPD, Asthma, or Bronchitis requiring regular medical therapy

Yes No Sleep Apnea. _____ Do you use a CPAP mask at home? _____

Yes No Are you able to walk up a flight of stairs w/o getting short of breath?

Yes No Do you use oxygen at home?

General Health

Yes No Kidney Disease ___ Dialysis _____

Yes No Stroke

Yes No Liver cirrhosis

Yes No Diabetes ___ Insulin ___ oral medication

Yes No Have you ever had a complication or adverse reaction to anesthesia?

Yes No Cigarettes / alcohol / recreational drugs

Height _____ Weight _____

Gastroenterology

Yes No Have you had a colonoscopy in the last 10 years? If yes, when _____
and what was found? _____

Yes No Do you have a prior history of colon cancer or colon polyps? If so, when _____

Yes No Do you have relatives with previous polyps or colon cancer?
If so, what relative and at what age? _____

Please list your previous surgeries: _____