PLEASE SEND COMPLETED FORM TO **FALL HILL GASTROENTEROLOGY ASSOCIATES**
FAX: 540-369-6912
or email: Endo4103@FallHillGastro.com
or mail : Fall Hill Endoscopy Center
4103 Lafayette Blvd.
Fredericksburg VA 22408

Today's Date:_____
Patient Name: _____ **Age**: _____
Sex: □ Female □ Male **Date of Birth**: _____**Email** _____
Address:_____
City: _____ **State**: ____ **Zip**:_____
Home: (_____)_____-_____ **Work**: (_____)_____-_____ **Cell**: (_____)_____-_____
Preferred Method of Contact: □ Home Phone □ Work Phone □ Mobile / Cell Phone
O**ccupation**:_____
Primary Care Physician: _____
Referring Physician:_____
Primary Insurance:_____ **Subscriber ID**:_____
Insured name_____
Relationship_____
Secondary Insurance:_____ **Subscriber ID**:_____
Self Pay? □ Yes □ No
Preferred Pharmacy:_____
Pharmacy Address: _____ **City**: _____ **State**: ___**Zip**:_____
I consent to share my medical and demographic information shared with other health care entities.
□ Yes □ No

Physician Request: □ Dr. Monahan □ Dr. Mastri □ Dr. Comerford □ First Available

Height: _____ Feet **Weight**: _____ lbs.
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:

Allergies □ None □ Latex □ Peanuts □ Eggs
Allergies to medications: List medication and reaction:

I consent to obtaining a history of my medication purchased at pharmacies. □ Yes □ No

Current Medications, supplements or over-the-counter medicines: □ None
Name of medication Dose How often taken

Past or Present Medical Conditions □ None

Cardiovascular □ Coronary Heart Disease □ High Blood Pressure □ High Cholesterol □ Other (specify)

Kidney disease □ chronic kidney disease □ Dialysis

Pulmonary □ Asthma □ COPD □ Sleep apnea □ Other:

Endocrine □ Diabetes □ Thyroid disease □ Other:

Gastrointestinal □ Hemorrhoids □ Reflux □ Colon Polyps □ Liver disease
□ Crohn's Disease □Ulcerative colitis □ Colon cancer □ Other:

Behavioral Health □ Depression □ Anxiety □ Other:

Previous Procedures/Surgery
□ None □ Gastric bypass- when____ □ Joint replacement- when____ □ Hysterectomy- when____
□ Appendectomy- when____ □ Gall Bladder removal-when____
□ Colon surgery-why_____when____
□ Cancer surgery, type_____when____ □
Other:_____

Please list any other medical problems not listed above:

Diagnostic Studies/Tests
□ None □EGD/Upper Endoscopy- when____

□ Colonoscopy (listed above) □Flexible sigmoidoscopy-when___

□ Video capsule Endoscopy- when____
□ Other:____

Alcohol
□ None □ Beer □ Wine □ Liquor □ less than 7 per week □ more than 7 per week

Tobacco
□ current every day smoker □ current some day smoker □ former smoker, quit____
□ never smoker
Do you vape? □ Yes □ No

Drug Use
□ None
□ Recreational drug use □heavy drug use

Family Medical History
□ no knowledge of family history
No Family History of □ colon cancer □ colon polyps
Yes Family History of □ colon cancer □ colon polyps Which relative?_____

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

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 Open Access Colonoscopy Questionnaire. You will be contacted within 7 business days regarding the physician's recommendations. If you have not heard from our office after this time, please contact our office at 540-371-9696.
Thank you for choosing Fall Hill Gastroenterology Associates.

_____

For internal use only
Approved for Direct Access Colonoscopy at FHGEC_____

OR Consultation Office appointment requested due to
patient's_____
_____

Reviewer: _____
Date:_____