



PLEASE SEND COMPLETED FORM TO **FALL HILL GASTROENTEROLOGY ASSOCIATES**

Include front and back copies of your insurance card

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

Occupation: _____

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. **Be sure to include front and back copies of your insurance card.** 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

Reviewer: _____

Date: _____