

Original Date: January 14, 2008

Dates Revised:



COLONOSCOPY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
MR #	Reason for today's exam:	
Referring doctor:	Did you FAIL A COLONOSCOPY TODAY : <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last colonoscopy exam:

PERSONAL HEALTH HISTORY

Have you had a Colonoscopy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Date :	<input type="checkbox"/> Failed Colonoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Date :
Do you have any history of:	<input type="checkbox"/> Polyps	<input type="checkbox"/> Crohnes
	<input type="checkbox"/> Polyp removal	<input type="checkbox"/> Diverticulitis
	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Diverticulosis

List any medical problems that other doctors have diagnosed related to your visit today.

Surgeries

Year	Reason	Hospital

Family history of colon cancer or polyps

Year	Reason	Hospital

Follow up appointment scheduled: Yes No Date: _____