

Scheduling Nurse Initials: _____

Date: _____

Gastroenterology
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Phone: (319) 366-8695 | Fax: (319) 366-0795
unitypoint.org

PLACE _____

DATE _____

TIME _____

PROCEDURE _____

Male Female

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

PHONE: (HOME) _____ (CELL) _____ (WORK) _____

REFERRING PHYSICIAN: _____

_____ Have you ever had a colonoscopy in the past? If so when? _____

Where? _____ Is the report available? _____

_____ Personal history of colon polyps/cancer

_____ Family history of colon cancer or polyps? Relationship _____

Age <60 _____ >60 _____

_____ Are you having any bowel changes? (ie: diarrhea, constipation, blood in stool)

Do you have: _____ Frequent heartburn _____ Change in bowel habits

_____ Dysphagia _____ Chronic constipation

_____ Chronic PPI use _____ Chronic diarrhea

_____ Frequent blood in stools

Comments: _____

Past health history: History & Physical attached _____

_____ COPD/Asthma

_____ Seizures

_____ CAD/Stents

_____ Kidney problems

_____ HIV

_____ Pacemaker/AICD/Arrhythmia

_____ Diabetes

_____ Hepatitis B/C

_____ Sleep Apnea

_____ Stroke/TIA

_____ Liver problems/cirrhosis

_____ MRSA or VRE

Complete list of medications including dose, especially diabetic meds/blood thinners/NSAIDs

1. _____ 9. _____

2. _____ 10. _____

3. _____ 11. _____

4. _____ 12. _____

5. _____ 13. _____

6. _____ 14. _____

7. _____ 15. _____

8. _____ 16. _____

Please have patient check with their insurance for coverage.

Allergies:

_____ Patient is to check with their insurance

_____ Procedure Preference (St. Luke's, Mercy, or Surgery Center)

_____ Physician Preference