Beebe Gastroenterology
Open Access Colonoscopy Questionnaire

Beebe Gastroenterology has developed a program which allows some patients to schedule a screening colonoscopy without the need for an office visit before the procedure.

***Please note*: you must answer every question or we will not be able to schedule you for an Open Access Colonoscopy.**

INSTRUCTIONS

1. Complete this entire form. If you have questions, please contact our office.
2. Return this entire form to our officevia mail or fax.
3. Our office will review your information and contact you. If you qualify for an Open Access Colonoscopy, we will schedule your procedure. If you do not qualify, we will schedule you for an office visit to discuss your needs with one of our highly-skilled providers.

To return your completed form by mail:
Beebe GI
Attention: OAC
33663 Bayview Medical Drive, Unit 2
Lewes, DE 19958

To return your completed form by fax:
(302) 644-7162

To contact our office with any questions:
(302) 645-9325

PATIENT NAME: ______________________________ **DATE OF BIRTH:** ____________________

1. Open Access Colonoscopy at our institution is approved for select patients age 50 to 70.
   a. How old are you now? ______________________

   Those who desire colon cancer screening below age 50 or above age 70 are encouraged to schedule an office visit to determine if screening is medically appropriate.

2. Have you had a colonoscopy in the past? ◯ Yes ◯ No
   a. **If the answer is yes,** please provide the name and phone number of the physician/facility who performed the procedure, as well as the date.

   Name (physician and/or facility): ____

   Phone number: ______________________ Date (of procedure): ______________________

   If the procedure was not with Beebe Gastroenterology, please obtain a copy of the procedure report and any biopsy results and attach it to this questionnaire.

3. If colonoscopy was recommended because of family history of colon cancer or polyps, which relative had cancer or polyps and how old were they?

   Relative who had cancer or polyps: ________________ Age of relative at the time: ____________________

   Relative who had cancer or polyps: ________________ Age of relative at the time: ____________________

4. Do you currently have any gastrointestinal symptoms ◯ Yes ◯ No
   such as abdominal pain, bleeding, weight loss, difficulty swallowing, constipation, diarrhea, reflux, anemia, cirrhosis, hepatitis or hiatal hernia

5. Do you have or have you been treated for any of the following?

a. Ulcerative Colitis or Crohns disease ◯ Yes ◯ No

b. Heart attack, irregular heartbeat, coronary artery bypass or stent placement, congestive heart failure, Afib, or palpitations ◯ Yes ◯ No

c. Stroke, seizure, or diabetes ◯ Yes ◯ No

d. Renal failure, or dialysis ◯ Yes ◯ No

e. Cancer ◯ Yes ◯ No
If yes, have you had radiation or chemo? ◯ Yes ◯ No

f. HIV/AIDS? ◯ Yes ◯ No

g. Parkinson's disease, osteo or rheumatoid arthritis ◯ Yes ◯ No

h. Anxiety, depression, headaches, dementia ◯ Yes ◯ No

i. Sleep apnea, respiratory problems, COPD, emphysema, home oxygen, or active asthma? ◯ Yes ◯ No
If you have sleep apnea, do you use a CPAP? ◯ Yes ◯ No

j. Defibrillator, pacemaker, or artificial heart valve ◯ Yes ◯ No
If yes, what is the make and model? ______________________________

k. Diabetes, bleeding disorders or tuberculosis?

l. Organ transplant other than cornea? ◯ Yes ◯ No

m. Chronic pain, kidney failure, thyroid disease ◯ Yes ◯ No

6. Are you taking any medications for high blood pressure? ◯ Yes ◯ No

7. Do you experience chest pain or shortness of breath? ◯ Yes ◯ No

8. Do you smoke? ◯ Yes ◯ No Do you drink alcohol? ◯ Yes ◯ No
Do you use illicit drugs? ◯ Yes ◯ No *Intake of alcohol:* Daily _____ Weekly _____

9. Do you have any medication allergies? Latex Allergy? Please list.

____

10. Do you take any blood thinners other than aspirin? ◯ Yes ◯ No

11. List all medications that you take including herbals, over the counter medications, vitamins, CBD, or medical marijuana.

____

____

PATIENT NAME: ______________________________ **DATE OF BIRTH:** __________________

12. Have you had any difficulty in the past with anesthesia other than nausea? ◯ Yes ◯ No

13. Have you had colon surgery? ◯ Yes ◯ No

14. Have you had any of the following surgeries?
    a. obesity surgery ◯ Yes ◯ No
    b. appendectomy ◯ Yes ◯ No
    c. gallbladder removal ◯ Yes ◯ No
    d. cesarean section ◯ Yes ◯ No
    e. other surgeries ____

15. Are you able to walk without help for 2 blocks or more? ◯ Yes ◯ No

16. Are you able to do yard work, house work, carry groceries? ◯ Yes ◯ No

17. Do you have any type of disability? ◯ Yes ◯ No
    If yes, please list ______________________________

18. What is your height? __________
    What is your weight? __________
    BMI _______ (for office staff to complete)

19. Name of cardiologist ____

20. Name of pulmonologist ______________________________________

21. Have you had a positive ColoGuard? ◯ Yes ◯ No ◯ Unsure

PATIENT NAME: ______________________ **DATE OF BIRTH:** ______________

Patient statement for open access colonoscopy:

I have reviewed the open access colonoscopy questionnaire and have answered all the questions truthfully to the best of my knowledge.

Patient signature: ______________________ Date: ____________

Last Name ______________________ First name ______________________

Address ______________________ Apt # ____________

City ______________________ State ________ Zip Code ________

Email Address ______________________

Home phone ______________________ Cell phone ______________________

Date of birth ______________________

Sex: ◯ M ◯ F Marital status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Race ______________________ Language Spoken ______________________

Ethnicity: ◯ Hispanic or Latino ◯ Non-Hispanic or Latino

Emergency contact ______________________ Phone # ______________________

Pharmacy Name and phone number ______________________

Primary care provider and phone number ______________________

Primary insurance: ______________________ ID ______________________

Secondary insurance: ______________________ ID ______________________