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 office, via mail, fax, or drop off.
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:
302-645-4920

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

Patient Name _____ Date of birth _____ Sex: ☐ M ☐ F

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Email Address _____

Home phone _____ Cell phone _____

Check one: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner

Race _____

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 _____ (must have ID)

Secondary insurance: _____ ID _____ (must have ID)

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1. 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 and a copy of the procedure report and biopsy results. *If your procedure was done at Beebe GI or done more than 10 years ago, there is no need for the report.*

   Name and address (physician and/or facility): _____

   Phone number: _____ Date (of procedure): _____

   Did you have polyps? ☐ Yes ☐ No

2. Family history of colon cancer? (circle relative) Mother Father Sibling Child Age of onset: _____

   Family history of colon polyps? (circle relative) Mother Father Sibling Child Age of onset: _____

3. If another doctor referred you for colonoscopy, what was the reason? _____

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

   _____

   _____

5. Do you have or have you been treated for any of the following? (circle all that apply)

Crohns disease	Ulcerative Colitis	Abdominal pain	Bleeding	Weight Loss
Difficulty swallowing	Constipation	Diarrhea	Reflux	Anemia
Liver disease	Hepatitis	Hiatal hernia	Nausea	Vomiting

Beebe Healthcare | Beebe Healthcare Perioperative Patient Questionnaire
COLONOSCOPY/ENDOSCOPY PROCEDURES

Surgeon: _____

Primary Care Physician: _____ Phone: _____

Cardiologist (heart doctor): _____ Phone: _____

Pulmonologist (lung doctor): _____ Phone: _____

PATIENT IDENTIFICATION LABEL

Patient Name: _____
Last *First* *Middle*

DOB: _____ Age: _____ ☐ Male ☐ Female

Height: _____ Weight: _____ BMI _____

Allergies & Reactions: _____

Phone: _____

Cell: _____

Date of Last:
☐ EKG: _____ ☐ Stress Test: _____
☐ ECHO: _____ ☐ Cardiac Cath: _____

Please DO NOT leave blanks. Answer YES below to any treatment, or taking medication(s) for, or diagnosis of:

Can you walk up a flight of stairs without rest? ☐ Yes ☐ No

Can you do light housework: dusting, wash dishes? ☐ Yes ☐ No

My exercise is limited by shortness of breath? ☐ Yes ☐ No

My exercise is limited by chest pain? ☐ Yes ☐ No

Blood Thinner? ☐ Yes ☐ No
Type:
If yes, instructed to stop? ☐ Yes ☐ No
Last dose to be taken on: _____

CARDIOVASCULAR

Coronary Artery Disease ☐ Yes ☐ No
Heart Stent(s) ☐ Yes ☐ No
Heart Failure ☐ Yes ☐ No
–Date of Diagnosis _____
–Are symptoms getting worse? ☐ Yes ☐ No
Heart Arrhythmias ☐ Yes ☐ No
–(SVT, A-Fib, Blocks, Bradycardia)
Aortic or Mitral Stenosis ☐ Yes ☐ No
Heart Attach/MI ☐ Yes ☐ No
–Date(s) _____

Pacemaker ☐ Yes ☐ No
AICD/Defibrillator ☐ Yes ☐ No
Make: _____
Model: _____
Last Checked: _____

SURGICAL HISTORY

Prior General Anesthesia ☐ Yes ☐ No
Anesthesia Complications ☐ Yes ☐ No
Family Anesthesia Complications ☐ Yes ☐ No

LUNG

Do you use oxygen? ☐ Yes ☐ No
COPD/Emphysema ☐ Yes ☐ No
Sleep Apnea ☐ Yes ☐ No
CPAP / BIPAP ☐ Yes ☐ No

GASTROINTESTINAL

Reflux/Indigestion ☐ Yes ☐ No
Last colonoscopy: Year _____
History of Colon Polyps ☐ Yes ☐ No
Last endoscopy: Year _____
Family history of colon cancer ☐ Yes ☐ No
Positive Cologuard ☐ Yes ☐ No

NEURO

Seizures ☐ Yes ☐ No
Last seizure: _____
Stroke / Mini-Stroke ☐ Yes ☐ No
Last seizure: _____

KIDNEY & ENDOCRINE

Diabetes Mellitus ☐ Yes ☐ No
Insulin Dependent ☐ Yes ☐ No
Non-Insulin Dependent ☐ Yes ☐ No
Daily Blood Sugar Range / HBA1C:
_____
Kidney Failure ☐ Yes ☐ No
Peritoneal Dialysis ☐ Yes ☐ No
Hemodialysis ☐ Yes ☐ No
Days of Week: _____

I understand the information I provide is essential to determine my treatment. I have answered all questions truthfully:

Patient Signature: _____ Date: _____ Time: _____

Staff Signature: _____ Date: _____ Time: _____