

PRE-COLONOSCOPY HISTORY

DATE: \_\_\_\_\_ NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

GENDER: \_\_\_\_\_ HOME#: \_\_\_\_\_ WORK#: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

List all chronic medical illness (e.g. Hypertension, diabetes, heart or lung disease) if any: (Attach additional sheets if needed)

- 1. \_\_\_\_\_ 5. \_\_\_\_\_
- 2. \_\_\_\_\_ 6. \_\_\_\_\_
- 3. \_\_\_\_\_ 7. \_\_\_\_\_
- 4. \_\_\_\_\_ 8. \_\_\_\_\_

List major surgical procedures you had in the past, if any: (Attach additional sheets if needed)

- 1. \_\_\_\_\_ 3. \_\_\_\_\_
- 2. \_\_\_\_\_ 4. \_\_\_\_\_

List all medications with dose and frequency, if any: (Attach additional sheets if needed)

- Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_
- Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_
- Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_
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- Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_
- Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_
- Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

List all drug allergies, if any: \_\_\_\_\_

List all family members (1<sup>st</sup> and 2<sup>nd</sup> degree relatives) that have been diagnosed with colon or uterine cancer and age of diagnosis, if any: \_\_\_\_\_

\_\_\_\_\_

Have you had a colonoscopy in the past?  Yes  No If yes, indicate date and reason for colonoscopy: \_\_\_\_\_

\_\_\_\_\_

Name of physician who performed colonoscopy: \_\_\_\_\_

What were the findings? \_\_\_\_\_

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\*\*\*OFFICE USE ONLY\*\*\*

MD APPROVAL:  Yes  No Office Visit  SIGNATURE: \_\_\_\_\_

PREP(S):  TRILYTE (Standard Prep)  1/2 LYTELY  GOLYTELY  MOVI PREP  OTHER: \_\_\_\_\_

MEDICATIONS TO HOLD: \_\_\_\_\_

DOCTOR:  Mourani  Tarakji DATE: \_\_\_\_\_ TIME: \_\_\_\_\_  VDHC  OTHER: \_\_\_\_\_