Middlesex Gastroenterology Associates

Screening Colonoscopy Information

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Sex:** **Marital Status:**

Race: _Ethnicity:_____**Occupation:** _____

Address: _____

City:_____**State:**_____**Zip:**_____

Email: _____

Primary Number: _____**Home:**_____

Cell:_____**Work:**_____

Pharmacy:_____**Location:**_____

_ **PBM Consent?** *(to electronically send prescriptions directly to pharmacy)*

Emergency Contact: _____**Phone:**_____

Relationship:_____

Insurance:_____

Policy/Member ID: _____

Secondary Insurance:_____

Policy/Member ID:_____

If you can send a copy with your insurance card(s) long with this form

Primary Care Physician:_____**Last Physical?**_____

OB/GYN:

Cardiology: Cardiologist?

Any other specialists? **If yes, who/why?**

Have you been seen by us before? **If Yes, who?**

Do you have a previous GI? **If Yes, Who?**

Medical Information

Are you taking any Blood Thinners? **If yes, what?**

Are you a Diabetic? **If yes, are you Insulin Dependent?**

Any current GI symptoms? **If yes, what symptoms?**

Have you ever had MRSA? **If Yes, When?**

Weight: _____ Height:_____ Disability: _____

Latex Allergy? **If yes, reaction/symptom? _____**

Anesthesia Allergy: **If yes, reaction/symptom? _____**

Tobacco Use? **Former/Quit Date:**

Alcohol Use? **Former/Quit Date:**

Have you ever had a Colonoscopy? **If Yes, When/Where?_____**

What were the findings? _____

In the last 4 years have you had:

A Barium Enema Study: **When:_____Findings: _____**

A Sigmoidoscopy: **When:_____Findings: _____**

Colon Surgery: **When:_____Findings: _____**

Colostomy? **When:_____Where: _____**

- Do you have any special needs, devices or disabilities? **If Yes, Explain: _____**

Do you have sleep apnea? **If yes, do you use a CPAP/BIPAP?**

Do you snore loud enough to be heard through closed doors?

Do you often feel tired, fatigued or sleepy during the day?

Has anyone observed you stop breathing during your sleep?

Have you ever had a Sleep Study? **If Yes, when and what were the findings:**

_____

Allergies:

Do you have any allergies to food or drugs? If so, please list below:

Food Allergy	Reactions

Drug Allergy	Reactions

Current Medications:

Are you currently taking any medications prescribed or over the counter? If so please list below:

Prescribed Medication	Dosage	Frequency

Are you taking any medication over the counter?

If yes, please write what you are taking, the dosage and frequency:

_____

_____

_____

_____

_____

Past & Current Medical History:

If anything applies to you now or has in the past, please check appropriate box:

Diagnosis	Current	Past	Additional Info
Angina	☐	☐	
Arrhythmia	☐	☐	
Artificial Heart Valve	☐	☐	
Defibrillator	☐	☐	
Endocarditis	☐	☐	
Heart Attach	☐	☐	
High Cholesterol	☐	☐	
High Blood Pressure	☐	☐	
Low Blood Pressure	☐	☐	
Pacemaker	☐	☐	
Rheumatic/Scarlet Fever	☐	☐	
Stroke	☐	☐	
Personal History of Colon Cancer	☐	☐	
Personal History of Colon Polyps	☐	☐	
Crohn's Disease	☐	☐	
Ulcerative Colitis	☐	☐	
Abdominal Pain	☐	☐	
Abdominal Bloating	☐	☐	
Black Colored Bowel Movements	☐	☐	
Rectal Bleeding	☐	☐	
Constipation	☐	☐	
Diarrhea	☐	☐	
Mucus Stools	☐	☐	
Diverticulosis	☐	☐	
Hemorrhoids	☐	☐	
Liver Cirrhosis	☐	☐	
Difficulty Swallowing	☐	☐	
GERD	☐	☐	
Heartburn	☐	☐	
Nausea	☐	☐	
Ulcers	☐	☐	
Vomiting	☐	☐	
Weight Loss	☐	☐	
Asthma	☐	☐	
COPD	☐	☐	
Emphysema	☐	☐	
Pulmonary Embolism	☐	☐	
Pulmonary Hypertension	☐	☐	
Tuberculosis	☐	☐	
Epilepsy	☐	☐	
Migraines	☐	☐	
MS	☐	☐	
Seizures	☐	☐	
Anemia/Type:	☐	☐	

Past & Current Medical History Continued:

Diagnosis	Current	Past	Additional Info
Bleeding Disorder	☐	☐	
Blood Clots	☐	☐	
Hepatitis/Type	☐	☐	
Vascular Disease	☐	☐	
Diabetes	☐	☐	
Thyroid Disease	☐	☐	
HIV	☐	☐	
AIDS	☐	☐	
Endometriosis	☐	☐	
Kidney Problems	☐	☐	
Personal History of Cancer & Type	☐	☐	

Are there any other diagnosis that you have that were not listed?

If Yes, please explain: _____

Family Medical History:

Check off anything applies to any of your relatives (parents, grandparents, siblings, aunts/uncles)

Are you adopted?

Family History Diagnosis	*Relative(s) / Age*
Colon Disease	
Colon Polyps	
Colon Cancer	
Breast Cancer	
Ovarian Cancer	
Uterine Cancer	
Gastric Cancer	
Ulcer Disease	
Any Other Kinds of Cancer	
Other:	

Is there any other family history?

If Yes, explain: _____

Surgical History

Have you had any serious injuries or surgeries?

If so, please list what surgery and when:

_____
_____
_____
_____
_____

Do you have any procedure requests? **If yes, what are the requests?**

Have you had your COVID Vaccine? **If Yes, which Vaccine?**

Have you completed the COVID Vaccine Series? If so, when?_____

Have you had your COVID Booster? If so, which vaccine and date? _____

Middlesex Gastroenterology Associates will review the above information filled out. Once reviewed, you will receive a call from our office within 1 week to schedule. In some cases, patients will need to come in for an office visit prior to their colonoscopy to schedule.

If you prefer to be emailed and/or have a text message sent instead, please advise that when sending this form back to our office.

Please keep in mind, your procedure time is done by the facility. If you are looking for a specific procedure time, please disclose when scheduling.

These forms are valid for 6 months.

By signing below you are confirming that the above information regarding your health history is accurate.

Patient Name: _____

Signature: _____Date: _____

Send Form Back To By Mail, Fax or E-Mail

Address:
Middlesex Gastroenterology Associates Attn: Screenings
410 Saybrook Road, Suite 201 Middletown, CT 06457

Fax:
860-346-9687

Email:
screenings@middlesexgastro.com