



Flagstaff Surgical Associates • Gastroenterology

Pre-Procedure Questionnaire

Patient name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Phone # \_\_\_\_\_

Referring Provider or Primary Care Provider: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Height: \_\_\_\_\_' \_\_\_\_\_" BMI (office will complete): \_\_\_\_\_

Insurance \_\_\_\_\_ Pharmacy \_\_\_\_\_ Email \_\_\_\_\_

Procedure:  Colonoscopy  EGD

Reason for procedure:  Screening  Surveillance  Diagnostic

Do you have an issue where you feel you should speak to a provider before your procedure?  Yes  No

Do you have a **personal or family history** of colon cancer?  Yes  No

If yes, who, and what age where they diagnosed?

Who	Age at Diagnosis
<input type="checkbox"/> Self	
<input type="checkbox"/> Mother	
<input type="checkbox"/> Father	
<input type="checkbox"/> Sibling	

Have **you** had a colonoscopy:  Yes  No ; Who was the physician that performed the procedure?

If so, where, when, any problems or concerns with the procedure?  Yes  No Do you know the results?  Yes  No

Would you be willing to discuss these results and/or symptoms in an office visit?  Yes  No

Where	When (Year)	Complications/Concerns	Results

**In the last 12 months** have you been to the emergency department, or hospital stay?

Yes  No If so why, where, and when?

Why	Where	When

**In the last 12 months** have you had any **stool** testing?  Yes  No

Have you had a **Cologuard**?  Yes  No

Have you had a **FIT** test or **FOB** test?  Yes  No

If so, when, what were the results, and who ordered the test?

When	Results	Ordered By

Are you **currently** experiencing any of the following symptoms (yes or no)?

Change in bowel habits:  Yes  No

If yes, explain how: \_\_\_\_\_

Abdominal pain:  Yes  No

Constipation:  Yes  No

Diarrhea:  Yes  No

Rectal bleeding:  Yes  No

Do you have a **personal history** of any of the following (yes or no)?

Kidney disease or impaired kidneys:  Yes  No



**Cardiac issues including:**

Heart attack:  Yes  No

Heart failure:  Yes  No

Irregular heart rhythm:  Yes  No If yes,

**Do you have** (yes or no):

An Artificial heart valve:  Yes  No

Any implanted medical device (pacemaker, AICD, etc.):  Yes  No

If yes what kind and who monitors it?

What Kind?	Who Monitors it?

Are you taking **anticoagulation** medication?  Yes  No

If yes, which one, and who prescribes it?

Medication	Who prescribes it?
Aspirin (how much)	
Coumadin	
Plavix	
Xarelto	
Pradaxa	
Eliquis	
Effient	
Jantoven	
Other:	

**Who** is your cardiologist/facility? \_\_\_\_\_

When did you **last see** your cardiologist? \_\_\_\_\_

**Current Drug Allergies:**  None  Yes — please specify below

1.	2.	3.
4.	5.	6.

**Current Medical Conditions:**  None  Yes — please specify below:

1.	2.	3.
4.	5.	6.

**Current Medications:**  None  Yes — please specify below:

1.	2.	3.	4.
5.	6.	7.	8.

Are you **currently** taking a GLP-1 medication?      None      Yes - please specify below:

Mounjaro	Zepbound	Ozempic	Rybelsus
Victoza	Trulicity	Wegovy	Byetta

**If YES, we will need you to stop taking it 10 days prior to colonoscopy procedure.**

**Office will complete the following:**

Date/time of the procedure: \_\_\_\_\_ w/ Dr. \_\_\_\_\_

Facility:  FEND  FMC

Colonoscopy Prep:  Printed RX     eRX     Sample given to patient.

Instructional paperwork:  Printed     Emailed     Paper Mailed     Patient Portal