

# DIRECT COLONOSCOPY SCREENING



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ E \_\_\_\_\_

- 1. Do you have any drug allergies? Yes / No: \_\_\_\_\_
- 2. Current medications: \_\_\_\_\_
- \*3. Do you have any GI symptoms such as unexplained abdominal pain, uncontrolled heartburn, changes in bowel habits, unexplained nausea/vomiting, chronic diarrhea, blood in stool? Yes / No
- \*4. Are you taking any blood thinners other than aspirin 81mg? Such as Coumadin (warfarin), Plavix (clopidigrel), Xarelto (rivaroxaban), Eliquis (apixaban), Pradaxa (dabigatran), Effient (prasugrel), Lovenox (enoxaparin)? Yes / No
- \*5. Are you taking any GLP-1 agonists or any other weight-loss medications such as Wegovy, Mounjaro, Ozempic, Trulicity, Rybelsus, Saxenda, Victoza, Zepbound, Byetta, Bydureon, or Adlyxin? Yes / No
- 6. Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ \*Morbidity obesity with BMI >35? Yes / No
- 7. Do you currently see or have you previously seen a cardiologist? Yes / No
- \*8. Do you have any of the following medical conditions?
  - Chronic Obstructive Pulmonary Disease- COPD? Yes / No
  - Congestive Heart Failure- CHF? Yes / No
  - Obstructive Sleep Apnea- OSA? Yes / No
  - Heart attack, stroke, or heart stent placed in the last year? Yes / No
  - Pulmonary embolism or Deep vein thrombosis in the last 6 months? Yes / No
  - Liver or Kidney Disease? Yes / No
  - Chronic lung disease requiring oxygen? Yes / No
  - Pacemaker or defibrillator? Yes / No
  - Asthma or shortness of breath? Yes / No
- 9. Have you had a previous colonoscopy or cologuard? Yes / No \*Normal / Abnormal \_\_\_\_\_
- \*10. Do you have any questions for the surgeon? Yes / No
- 11. Have you seen your Primary Care Provider within the last year? Yes / No
- 12. Have you received the colonoscopy prep instructions? Yes / No
  - If not received: \_\_\_\_\_ Patient Pick-Up \_\_\_\_\_ Mailed \_\_\_\_\_ MyChart
  - Surgeon: \_\_\_\_\_ Dr. Kamlitz \_\_\_\_\_ Dr. Grigereit
  - Date Scheduled: \_\_\_\_\_

*\*Any yes answer will need to be reviewed by surgeon or in clinic consult required*

Screening RN Signature \_\_\_\_\_

Date \_\_\_\_\_