



FAST ACCESS COLONOSCOPY

Atlanta Gastroenterology Specialists PC

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(Please email paperwork along with the front and back of your insurance card.)

MEDICAL QUESTIONNAIRE FOR SCREENING COLONOSCOPY

Date: _____

Name: _____ Age: _____ Date of Birth: _____

Sex: M / F Weight _____ If over 350 lbs. please contact office

When would you prefer to schedule to procedure _____?

Occupation: _____

Referring physician, _____

The reasons for the colonoscopy are (check all that apply):

Screening (age over 45) _____ The American Cancer Society has revised the age for screening to 45

Family history of colon cancer _____ If so who in your family and what age _____

Personal history of colorectal cancer _____

Hidden blood found in stool

Cologuard tests: Positive Negative

Blood test abnormality _____

History of Ulcerative colitis or Crohns Disease _____

Symptoms: Rectal bleeding _____
Change in bowel habits _____
Constipation _____
Diarrhea _____

Have you ever had a colonoscopy before Yes No

When? _____

Who performed the procedure? _____

Findings _____

If polyps were found were they precancerous? _____

Any Complications of the procedure? _____

Do you suffer from heartburn, GERD or trouble swallowing? _____

Have you ever had an upper endoscopy? _____ If so when? _____

List Medications you are currently taking:

Do you have any of the following? (Please circle)

Hypertension Coronary Artery Ds Valvular Heart Ds COPD
Hepatitis AIDS or HIV Diverticulitis Thyroid ds Asthma Chronic Renal Failure
Transplant S t r o k e TIA Seizures MS Venous thrombosis Embolism

MUST ANSWER: Are you taking Blood thinners (Ex:Coumadin, Plavix, Aggrenox, Pradaxa, Eliquis, ASA, etc.)

Please circle one or circle NO

Anti-inflammatory medication (Advil, Nupren, Ibuprofen etc.)

Yes, _____ which ones _____ No

Medication Allergies Please list _____

_____ If you have had a colonoscopy previously, did you have any problem with the bowel prep?

Do you recall the prep? _____

With the sedation? _____

Any problems afterwards?

Do you have difficulty breathing (asthma, COPD, emphysema)? Do you use _____
supplemental oxygen? _____

Have you ever had a problem with sedation or anesthesia?

MUST ANSWER Are there any problems with your kidney function (renal failure)? Yes No

Have you had problems with low or high potassium or calcium in your blood? Yes No

Do you have an implantable defibrillator? _____

Do you have a pacemaker? _____

Have you been troubled by chest pain, chest pressure or smothering in the past year? Yes or no

Have you ever had a heart attack? _____ If so when _____

Have you had cardiac stents inserted _____ If so when _____

Do you have atrial fibrillation? _____ Do you have any other abnormal heart rhythm?

Are you aware of any problem with the valves of your heart or have you had heart valve surgery? Do you need antibiotics for procedures? _____

Do you smoke cigarettes? Present past How many per day? _____

For how many years? _____

How many alcoholic beverages do you consume in a week _____

Have parents or siblings had colon polyps or colon cancer? _____

Who? _____

Please list all previous surgeries (include approximate dates)

Other than for surgeries, have you ever stayed overnight in a hospital? _____ If so, please give the medical conditions that were treated and approximate dates: _____

Have you ever been diagnosed with cancer? _____ If yes, please provide primary organ involved and date first diagnosed as well as treatment and current status

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Have you ever been diagnosed with cancer? _____ If yes, please provide primary organ involved and date first diagnosed as well as treatment and current status _____

My typical bowel pattern is:

- (a) 1-2 per day _____
- (b) 2-3 per week _____
- (c) 1 per week _____
- (d) 1 every 2 weeks _____
- (e) 3 or more per day (give number) _____

Is there anything else we should know in advance about your personal or past medical history? If so please be very specific

Please Fax the completed forms to 678-957-0047.

Or email to fastaccess@atlgastrspec.com

You will receive a call back within 48 hour to schedule after Dr. Sangha reviews the questionnaire If you do not hear from us please call the office

Please Note:

Screening colonoscopies are usually fully covered by insurance if you meet their criteria, though this is not always guaranteed. If you have any preexisting conditions, your insurance may classify the procedure as diagnostic. We will work with your insurance to precertify the procedure and will inform you of any financial responsibility. If a polyp or other abnormality is discovered during the procedure, we will adjust the coding to indicate that the intent was a screening. However, please note that this may lead to additional charges based on your insurance policy. If you have any questions, feel free to contact our office.

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