PLEASE SEND COMPLETED FORM TO **FALL HILL GASTROENTEROLOGY ENDOSCOPY CENTER**
__Include__ front and back copies of your insurance card
FAX: 540-369-6912
or email: Endo4103@FallHillGastro.com
or mail : Fall Hill Endoscopy Center
4103 Lafayette Blvd.
Fredericksburg VA 22408

Today's Date:________________

Patient Name:____**Age**: _____
Sex: □ Female □ Male **Date of Birth**:_________________**Email**______________________
Address:____
City:_______________________**State**:_____**Zip**:________
Home: (______)______-________**Work**: (______)______-__________**Cell**: (______)______-________
Preferred Method of Contact: □ Home Phone □ Work Phone □ Mobile / Cell Phone
Occupation:____________________________
Primary Care Physician: _________________________
Physician phone #:______________________
Primary Insurance:______________________________**Subscriber ID**:_________________________
Insured name_____________________________________
Relationship_____________________________
Secondary Insurance:___________________________**Subscriber ID**:_________________________
Self Pay? □ Yes □ No
Preferred Pharmacy:____
Pharmacy Address:____________________________**City**:________________**State**:___**Zip**:_______
****I consent*** to share my medical and demographic information shared with other health care entities
□ Yes □ No

Physician Request: □ Dr. Monahan □ Dr. Mastri □ Dr. Comerford □ First Available

Height:_______Feet **Weight**:________lbs.
Have you had a colonoscopy previously? □ Yes □ No
If yes, please provide the following details:
Procedure Year:
Performing Physician:
Facility: City, State:
Procedure Findings:
Did you have any problems with the bowel prep? □ Yes □ No
If yes, please specify the problems you experienced with the bowel prep:

Allergies □ None □ Latex □ Peanuts □ Eggs
Allergies to medications: List medication and reaction:

***_I consent_ to obtaining a history of my medication purchased at pharmacies.**□ Yes □ No

Current Medications, supplements or over-the-counter medicines: □ None
Name of medication Dose How often taken

Past or Present Medical Conditions □ None

Cardiovascular □ Coronary Heart Disease □ High Blood Pressure □ High Cholesterol □ Other (specify)

Kidney disease □ chronic kidney disease □ Dialysis

Pulmonary □ Asthma □ COPD □ Sleep apnea □ Other:

Endocrine □ Diabetes □ Thyroid disease □ Other:

Gastrointestinal □ Hemorrhoids □ Reflux □ Colon Polyps □ Liver disease
□ Crohn's Disease □Ulcerative colitis □ Colon cancer □ Other:

Behavioral Health □ Depression □ Anxiety □ Other:

Previous Procedures/Surgery
□ None □ Gastric bypass- when____ □ Joint replacement- when____ □ Hysterectomy- when____
□ Appendectomy- when____ □ Gall Bladder removal-when____
□ Colon surgery-why__________________________________when____
□ Cancer surgery, type________________________________when____□
Other:______________________________

Please list any other medical problems not listed above:

Diagnostic Studies/Tests
□ None □EGD/Upper Endoscopy- when____

□ Colonoscopy (listed above) □Flexible sigmoidoscopy-when___

□ Video capsule Endoscopy- when____
□ Other:____

Alcohol
□ None □ Beer □ Wine □ Liquor □ less than 7 per week □ more than 7 per week

Tobacco
□ current every day smoker □ current some day smoker □ former smoker, quit____
□ never smoker
Do you vape? □ Yes □ No

Drug Use
□ None
□ Recreational drug use □heavy drug use

Family Medical History
□ no knowledge of family history
No Family History of □ colon cancer □ colon polyps
Yes Family History of □ colon cancer □ colon polyps Which relative?________________

Check any gastrointestinal symptoms that you have had in the past 3 months: □ Frequent abdominal pain □ Constipation □ Diarrhea lasting more than 1 week □ Black Stools □ Rectal Bleeding □ Frequent nausea or vomiting □ None

If you have anything to add that wasn't included in this form, please describe below:
____
____

***I declare that the information I have given on this form is to the best of my knowledge, true and complete.** Patient Name: ____
Date:___________________________________
Patient Signature:____
Date:______________________________

Thank you for completing the Open Access Colonoscopy Questionnaire. **Be sure to include front and back copies of your insurance card.** You will be contacted within 7 business days regarding the physician's recommendations. If you have not heard from our office after this time, please contact our Endoscopy Center at 540-656-2380.
Thank you for choosing Fall Hill Gastroenterology.

For internal use only
Approved for Direct Access Colonoscopy at FHGEC__________

OR Consultation Office appointment requested due to
____
____

Reviewer:________________
Date:____________________

PLEASE ENSURE THE * AREAS ARE COMPLETE. This will expedite the process. Thank you!