DHPT
Digestive Health Partners of Texas

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Colonoscopy Questionnaire

Date: _____ Physician: ☐ Yamini Maddala, M.D.

☐New Patient ☐Follow Up **Referring Physician:**_____

Patient Name: _____ DOB: _____ __

Sex: ■Male ☐Female ☐ Transgender

Email Address: _____ Cell Number: _____ Home Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Name of Health Plan: _____ Insured DOB: _____ __

Insurance ID: _____ Group Plan ID: _____

Pharmacy: _____ Pharmacy Phone/Location: _____

Have you had a Colonoscopy in the past? ☐Yes ☐No If Yes, When: _____ Where: _____

Results: ☐Normal ☐Polyps ☐Cancer ☐Other: _____

Weight: _____ Height: _____ BMI: _____ **> 50 make office visit**

Medications: Name, Dose, How Often ☐None

1. _____ ____
2. _____
3. _____ __
4. _____ _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Allergies: _____

Yes	No	
☐	☐	Do you have a history of Myocardial Infarction (Heart Attack)
☐	☐	/Unstable Angina/Heart Failure//Aortic Stenosis/Stents?
☐	☐	Are you taking any blood thinners, other than baby aspirin?
☐	☐	Do you have any breathing problems/lung disease? (COPD, Emphysema)
☐	☐	Are you on continuous or supplemental oxygen?
☐	☐	Are you on dialysis or diagnosed with kidney disease?
☐	☐	Any chance you could be pregnant?

STOP **If yes to any of the above six questions, schedule patient for an office visit**

- ☐ ☐ Do have high blood pressure? If yes, is it controlled with medication? ☐ Yes ☐ No
- ☐ ☐ Do you have a history of seizures?
- ☐ ☐ Are you diabetic? If yes, ☐Type I ☐ Type II
- ☐ ☐ Do you take prescription narcotics, anti-depressants, sleep aids, anxiety medication?
- ☐ ☐ Do you have sleep apnea? Do you use a CPAP? ☐ Yes ☐ No
- ☐ ☐ Do you have any bleeding or circulatory disorders? Stroke, Blood Clots, Other:_____
- ☐ ☐ Have you ever been diagnosed with cancer? If yes, what type: _____
- ☐ ☐ Have you had any problem with anesthesia? If yes, details: _____
- ☐ ☐ Have you had an organ transplant other than cornea? If yes, what type: _____

Submit

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