MRN: _____

Procedure
Date:_____
Time:_____
Neeraj, Singh, MD
LOC:
other: _____

Colon & Rectal Care Center Of Phoenix

Screening Questionnaire

Date: _____

Dr. Neeraj Singh
Ph 6232264025 / Fax 6232264229

Patient Name:_____DOB: _____

Best # to reach them: (_____)_____ PCP: _____

A positive response to the question may indicate that the direct access is not appropriate for this patient. Procedure schedulers will speak to the Surgeon and the surgeon will make final determination. If cardiac issues we will obtain a pre-op clearance from the patient's cardiologist.

		Yes	No
1.	Are you experiencing any GI issues such as constipation or diarrhea currently?	_____	_____
2.	Do you have difficulty swallowing, chronic acid reflux or upper abdominal pain?	_____	_____
3.	Under treatment for heart failure or valve related concerns?	_____	_____
4.	History of infection of the inner lining of your heart, rheumatic fever or heart stent?	_____	_____
5.	Do you have a pacemaker or defibrillator?	_____	_____
6.	Under treatment for kidney disease?		_____
7.	Do you use an oxygen machine?		_____
8.	On Anti-platelet or anticoagulation that can't be stopped 1 week prior?	_____	_____
9.	Under treatment diverticulitis or inflammatory bowel disease?	_____	_____
10.	*If female, could you be or are you pregnant?*	_____	_____
11.	Had recent positive test stating you have blood in your stool or anemia?	_____	_____

12. Have you had a colonoscopy previously Yes or No What year? _____
    If yes, did you have colon polyps Yes or No

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

    Screening colonoscopy guidelines vary by plan, if after your last colonoscopy you had colon polyps your insurance may deem this colonoscopy as diagnostic.

13. Any issues when having surgery with sedation or anesthesia? Yes or No
14. Do you have sleep apnea? Yes or No
15. Do you take any medications for pain or anything to help you sleep? Yes or No
16. Are you diabetic Yes or No
    If yes do you use medication_____or take shots_____?

17. Do you have any other medical issues not discussed above? _____

Height:_____Weight: _____ *Type your text*

Medication Allergies: Yes ( ) No ( ) _____

Surgery: Kidney heart and lung Yes ( ) No ( )

Allergy to Latex or Iodine Yes ( ) No ( )

Initials_____

Insurance:_____ID_____Group_____

Pharmacy: _____ **RX Sent ( )** **Instructions to patient mailed ( )**

Date of Surgery _____ Location: _____ Check in time _____