Direct Access Questionnaire

DHAT

Date: _____ Physician: _____ Referring Physician: _____

Patient Name: _____ DOB: _____

☐ New Patient ☐ Follow Up Home Phone: _____ Cell Phone: _____

Sex: ☐ Male ☐ Female ☐ Transgender Email Address: _____

Pharmacy: _____ Pharmacy Phone/Location: _____

Reason for Colonoscopy: ☐ Screening ☐ Hx Colon Ca ☐ Hx Colon Polyps ☐ FHx Colon Ca ☐ FHx Colon Polyps

Have you had a colonoscopy in the past? ☐ Yes ☐ No If yes, when: _____ where: _____

Result: ☐ Normal ☐ Polyps ☐ Cancer ☐ Other: _____

Do you have any gastrointestinal symptoms: ☐ Abdominal Pain ☐ Bleeding ☐ Anemia ☐ Other: _____

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

Medications: ☐ None (Name, Dose, How Often)

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
10 _____

Allergies: _____ ☐ NKDA

Yes	No	
☐	☐	Do you have an Internal Cardiac Device: Defibrillator/Pacemaker?
☐	☐	Do you have a history of Myocardial Infarction (Heart Attack)/Unstable Angina/ Heart Failure/Aortic Stenosis/Stents?
☐	☐	Do you have a personal or family history of malignant hyperthermia?
☐	☐	Do you have a tracheostomy (trach)?
☐	☐	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?

Physical Exam:

HEENT	NL	_____
NECK	NL	_____
LUNGS	NL	_____
CV	NL	_____
ABD	NL	_____
EXT	NL	_____
NEURO	NL	_____

Pt is medically stable for exam Y N

(Physician Signature Below)

If yes to any of the above 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: _____
☐ ☐ Do you drink alcohol? If yes, How often: _____ How much: _____
☐ ☐ How often do you have a bowel movement? ☐ Daily ☐ 2-3 x's day ☐ Every other day ☐ Other: _____

Scheduler: _____ Procedure Date: _____ Time: _____

Endo Center: ☐ OTEC ☐ RBEC ☐ CPEC ☐ PVEC ☐ NRHEC Other: _____

Prep: _____ ☐ Mailed ☐ Emailed

Reviewed by DHAT Physician: _____ Date: _____