

Procedure Scheduling Form

Name

DOB

Height

Weight

BMI (For office use)

Phone number

Primary Care Physician / Office Name

Requested Physician at CGH

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR HEALTH

Please check **Yes** or **No** and specify where asked

Yes **No**

- ☐ ☐ Have you been experiencing diarrhea for more than 6 weeks?
- ☐ ☐ Do you have Cirrhosis of the Liver?
If yes, what is the cause: _____
- ☐ ☐ Do you have Crohn's disease or Ulcerative Colitis?
- ☐ ☐ Have you had diverticulitis or colitis within the past 6 weeks?
- ☐ ☐ Are you currently having significant rectal bleeding (other than occasional hemorrhoidal bleeding)?
- ☐ ☐ Are you experiencing any unexplained abdominal pain or weight loss?
- ☐ ☐ Do you require dialysis or have chronic kidney disease under regular follow-up?
- ☐ ☐ Have you had major abdominal or chest surgery in the last 3 months?
• If yes, specify _____
- ☐ ☐ Have you had a seizure in the past 12 months, or a medication change in the last 6 months?
- ☐ ☐ Do you have any of the following in your Heart History?
- Pacemaker or Defibrillator
 - Heart stents or bypass surgery in the past 12 months
 - Heart failure, heart attack, or stroke in the past 12 months
 - Aortic stenosis or heart valve surgery
 - Abnormal heart rhythm (other than well-controlled atrial fibrillation)
 - Are you currently scheduled for any heart testing such as stress test?
- ☐ ☐ Do you have any of the following in your Lung History?
- Severe COPD/emphysema
 - Asthma requiring frequent rescue inhaler use
 - Need for supplemental oxygen
 - Shortness of breath with mild exertion (i.e 1 flight of stairs)
 - Are you currently scheduled for any lung testing such as pulmonary function test or CT scan of the chest?

- ☐ ☐ Are you taking insulin for Diabetes?
- ☐ ☐ Do you have more than mild Alzheimer's, Parkinson's, or dementia?
- ☐ ☐ Are you currently receiving radiation or chemotherapy?
- ☐ ☐ Do you take blood thinners other than aspirin?
(Examples include Coumadin® (warfarin), Lovenox, XARELTO® (rivaroxaban), AriXtra® (Fondaparinux), Plavix® (clopidogrel), Effient® (prasugrel), Eliquis® (apixaban), Brilinta™ (ticagrelor), etc.)
- ☐ ☐ Do you have any known bleeding disorders (i.e. ITP, hemophilia, von Willebrand disease)?
- ☐ ☐ Have you ever had an organ transplant (i.e Lung, Heart, Kidney, etc)
If yes, please specify which organ: _____

PLEASE PROVIDE US WITH MORE INFORMATION ABOUT YOUR GI HEALTH

Please check **Yes** or **No** and specify where asked

Yes No

- ☐ ☐ Have you had a colonoscopy before? When? _____
- ☐ ☐ Do you have a history of colon polyps? When? _____
- ☐ ☐ Has a first-degree relative (parent, sibling, child) had colon cancer?
If yes, who and what age? _____
- ☐ ☐ Have you ever had a positive Cologuard test?
If yes, when and what age? _____
- ☐ ☐ Do you have at least 3 bowel movements weekly without regular laxative use?

PLEASE PROVIDE US WITH MORE INFORMATION ABOUT YOUR GENERAL HEALTH AND MEDICATIONS:

Please check **Yes** or **No** and specify where asked

Yes No

- ☐ ☐ Do you take antibiotics before medical or dental procedures?
- ☐ ☐ Are you allergic to any Medications?
If yes, specify medication and reaction? _____
- ☐ ☐ Do you have sleep apnea and/or use a CPAP or BiPAP? _____
- ☐ ☐ Are you currently taking any GLP-1 medications?
If yes, which one?
- Weekly injectable Medication: Ozempic (Semaglutide), Bydureon (exenatide), Byetta (exenatide), Rybelsus (semaglutide), Wegovy (semaglutide), Victoza (liraglutide), Mounjaro (tirzepatide), Saxenda (liraglutide), Trulicity (dulaglutide), Zepbound (tirzepatide).
 - **Must stop 7 days before the procedure**
 - Daily medications -Byetta (exenatide), Rybelsus (semaglutide), Victoza (liraglutide), Saxenda (liraglutide)?
 - **You must stop 2 days before the procedure**
- ☐ ☐ Are you taking Phentermine?
• **You must stop 7 days before the procedure**

Please provide us a list of your current medications including prescription, non-prescription, and supplements

PAST MEDICAL HISOTRY

Check all that apply and specify where indicated.

- | | |
|---|---|
| ☐ No medical history | ☐ Gerd |
| ☐ Seizure disorder | ☐ Barrett's esophagus |
| ☐ Migraine | ☐ Peptic Ulcers |
| ☐ Glaucoma | ☐ Irritable bowel Syndrome |
| ☐ Depression / Anxiety | ☐ Pancreatitis |
| ☐ Thyroid Disease | ☐ Diabetes, type: _____ |
| ☐ Tuberculosis, when treated: _____ | ☐ Cancer type: _____ |
| ☐ HIV | ☐ High blood pressure |
| ☐ Hepatitis, type: _____ | ☐ Kidney Disease, type: _____ |
| ☐ Anemia | ☐ Other medical conditions: _____ |
| | _____ |

PAST SURGICAL HISTORY

Check all that apply and specify date of surgery

- | | |
|---|--|
| ☐ No surgical history | ☐ Flex Sigmoidoscopy (Date): _____ |
| ☐ Appendectomy (Date): _____ | ☐ Lung Surgery (Date): _____ |
| ☐ Gallbladder removal (Date): _____ | ☐ Joint Replacement or metallic hardware in the body (Date): _____ |
| ☐ Hernia Repair (Date): _____ | ☐ Back surgery (Date): _____ |
| ☐ Colon Surgery (Date): _____ | ☐ Breast surgery (Date): _____ |
| ☐ Small bowel surgery (Date): _____ | ☐ Hysterectomy (Date): _____ |
| ☐ Gastric Bypass (Date): _____ | ☐ Other: _____ |
| ☐ EGD (Date): _____ | _____ |
| ☐ EUS (Date): _____ | |
| ☐ ERCP (Date): _____ | |