COLONOSCOPY QUESTIONNAIRE

Name: _____ Date of Birth: _____

Please complete the information below and the enclosed paperwork. Be sure to sign and date the forms, and return to our office. ***When we receive the completed forms*** Dr. Lally will review your paperwork. ***Our office will contact you*** to schedule either a consultation or a date for your procedure.

♦ Please include a copy of the front & back of your insurance card(s) and photo identification. ♦

Please answer the following questions:

How often do you have a bowel movement?_____

Have you lost weight unexpectedly? Y☐ N☐

Has your energy level been normal? Y☐ N☐ If no, indicate changes_____

Is your appetite normal? Y☐ N☐ If no, indicate changes_____

Have you had hemorrhoids? Y☐ N☐ Are you bothered by them? Y☐ N☐

Please circle any of the listed problems below that are ***CURRENTLY ACTIVE*** and ***SIGNIFICANT*** at this time:

☐ Nausea/Vomiting	☐ Rectal Bleeding	☐ Excessive abdominal bloating
☐ Abdominal pain	☐ Abdominal cramping	☐ Tearing sensation with bowel movement
☐ Grey-colored stool	☐ Black tarry stool	☐ Anal pain during bowel movement
☐ Change in stool size	☐ Change in stool consistency	☐ Mucous during bowel movements

Briefly describe any changes: _____

Do you have any immediate family history of the following? (**Please check and indicate relationship**)

☐ Colon cancer _____

☐ Colonic polyps _____

☐ Crohn's disease or Ulcerative colitis _____

Other gastrointestinal complaints: _____

OFFICE USE ONLY

Received:	Consult Declined: N / S
□ ABN	Prep:
□ EKG	Pharmacy:
Labs:	Scheduled for:
D/C Rx:	Instructions:
Sleep Apnea:	

Sheila C.Lally, D.O., P.S.
22180 Olympic College Way, Ste.204
Poulsbo, WA 98370
(360)697-6547
Fax (360)697-9277