HOCKING VALLEY
Community Hospital

Please complete this form and return to 541 S.R. 664 N., Suite A, Logan, Ohio, 43138 or call (740) 380-1300.

Self-Referral Colonoscopy Questionnaire

First Name:	Last Name:	Date of Birth:
Mailing Address to receive prep and procedure instructions:		
Telephone Numbers:	Daytime:	Evening:
Referring/ Primary Care Provider:		
Referring/ Primary Care Provider Phone #:		
Insurance Plan:	ID#:	Group#:
Insured:	Group Name:	
Preferred Pharmacy:		
Reason for Visit:		
Procedure Being Requested: Colonoscopy		
Ethnicity/Race: **Caucasian African-American Asian Pacific Islander Hispanic Unknown**		
Sex:	Height:	Weight:
If Female, Have you reached menopause?		**Yes** **No**
Are you a female of child bearing age?		**Yes** **No**
NSAID Use: Advil, Motrin (Ibuprofen); Aleve (Naproxen sodium); Ascriptin, Bayer, Ecotrin (aspirin); Anaprox (naproxen sodium); Celebrex (celecoxib, sulindac); Daypro (oxaprozin, salsalate, diflunisal); Feldene (piroxicam) Indocin (indomethacin, etodolac); Mobic (meloxicam); Naprosyn (naproxen,nabumetone, ketorololac tromethamine); Vimovo (naproxen/esomeprazole); Voltaren (diclofenac)		
Anit-coagulant Use:(Plavix, Coumadin, Heparin, Lovenox, Pradaxa, Refludan, Arixtra, Xarelto, Eliquis, etc.)		
Allergies:		
Please list current medications and dosages:		

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Medical History

Previous Colon Cancer Screening: **Barium Enema** **Flex Sigmoidoscope** **Colonoscopy**	
Date of last colonoscopy: **None** **<5 years** **Almost 5 years** **6-9 years** **>10years**	
What provider performed last colonoscopy procedure?	
Result of Colonoscopy: Failed/Incomplete exam? **No Polyps** **<3 Polyps** **3-5 Polyps** **>5Polyps**	
Do you feel you need to be evaluated for any of the following GI symptoms: **Blood in stool** (K92.1) **Rectal Bleeding** (K62.5) **Abdominal pain** (R10.9) **Constipation** (K59.00) **Diarrhea** (R19.7) **Unexplained Weight Loss** (R63.4)	
Pulmonary History: **Shortness of Breath** **COPD** **Asthma** **Cough** **Sleep Apnea**	
Do you use a CPAP?: **Yes** **No**	Have you had a heart attack?: **Yes** **No**
Do you have a defibrillator or pacemaker?: **Yes** **No**	Are you diabetic?: **Yes** **No**
Have you had previous surgeries?: **Please list**	
Prior difficulty with Anesthesia or Sedation?: **Yes** **No** If yes, please explain	
Do you drink alcohol? Amount (1 can of beer, 1 glass of wine) **None** **<4 drinks/year** **Up to 3 drinks/week** **4-13 drinks/week** **14 or more drinks/week**	
Did you ever smoke?: **Yes** **No**	If yes, how many packs/day did you smoke?:
Have you quit smoking?: **Yes** **No**	
Do you have a parent or sibling who had colon cancer or rectal cancer?: **Yes** **No**	
If yes, then please put relationship and age at their diagnosis:	
Please add any additional comments:	