QUEEN CITY
GASTROENTEROLOGY
& HEPATOLOGY

Patient Open Access Colonoscopy Request

DATE _____

Patient Name _____ DOB _____

Primary Phone Number _____ Secondary Phone Number _____

Address _____

City _____ State _____ Zip Code _____ Email _____

Insurance name _____ Policy ID # _____

Group ID # _____ Primary Subscriber name _____

Referring Physician _____ Phone # _____ Fax # _____

Please Circle Yes or No to the following medical questions.

YES – NO Have you ever had a colonoscopy? If yes where and when? _____
YES – NO Do you have history of colon polyp or colon cancer?
YES – NO Do you have relatives with colon cancer? If yes, who? _____ Age at diagnosis? ____
YES – NO Coronary Artery Disease / Angina / Heart attack within the past 1 year?
YES – NO Congestive Heart Failure with hospitalization within the past 6 months?
YES – NO History of Artificial Heart Valve/ Defibrillator/ pacemaker placement?
YES – NO Emphysema, Asthma, Bronchitis, or sleep apnea that is not controlled?
YES – NO Kidney Disease on dialysis?
YES – NO Stroke within the past 1 year?
YES – NO Diabetes that is not controlled?
YES – NO Have you ever had a joint replacement within the last 1 year?
YES – NO Have you ever had a complication with anesthesia?
YES – NO Do you weigh more than 325 pounds?
YES – NO Do you see blood in your bowel movements or black stools?
YES – NO Do you have frequent constipation or diarrhea?
YES – NO Do you take blood thinning medication? (Coumadin, plavix, xarelto, pradaxa, other?)
YES – NO If you have a chronic medical condition, have you been seen by your physician / medical provider within the past 30 days? If yes please fill the information below.

Date of last exam_____ Primary Care Provider Name_____

Please list any active medical problems:

_____
_____
_____
_____
_____
_____
_____

Please list all medications including vitamins, prescription, and non prescription (include over the counter products) include dosage/ frequency, strength and last taken

Medication Name & Strength	Dosage	Last time taken

Do you have any allergies to any medication or food? If so please list your reaction below

_____
_____
_____

How did you hear about us ?

_____
_____

Once submitted, you will be contacted within three business days by our staff to review your history, verify your insurance, obtain a prescription for the bowel preparation, and receive final instructions for your colonoscopy. This form should never be used for medical emergencies.

Please return this completed form to our office via mail or secure fax.

Mail:
Queen City Gastroenterology
320 Lillington Ave, Suite 101
Charlotte, NC, 28204
Phone: (704) 362- 4403

Fax:
(704) 362- 4405