Radha Tamerisa, MD
25230 Kingsland Blvd Suite 102 Katy, TX 77494
Phone: 281-869-3009 Fax: 832-437-5182

PRE-COLONOSCOPY PATIENT QUESTIONNAIRE

For Katy Integrative Gastroenterology

INTRODUCTION

This form is intended for HEALTHY PATIENTS ONLY, who are not experiencing ANY GI symptoms. If you are experiencing GI symptoms or any GI issues, please call the office to schedule an appointment at 281-869-3009 option 1.

Colonoscopy is a relatively short and safe procedure. However, as with any medical procedures, complications are possible (for details, please read the included brochure "COLONOSCOPY "). To minimize the risk of unexpected events or possible complications, please read carefully and complete the questionnaire below. It is important that you answer all questions as accurately as possible. Answers to questions 9 and 10 will be updated at the time of colonoscopy by your physician. At that time, you will also be examined and you will have the opportunity to discuss any important issues with your physician.

PATIENT DEMOGRAPHIC INFORMATION

Name: _____ Social Security Number: _____ DOB: _____ Age:_____Sex: _____

Address: _____ City: _____ Zip Code: _____ Race:_____ Ethnicity: _____

Preferred Language: _____ Home Phone: _____ Cell Phone: _____

E-mail address: _____

Patient Employer: _____Phone Number: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Emergency contact: _____ Relationship: _____Phone:_____

First and Last Name of Referring physician:_____ ❑ I do not have a referring physician

INSURANCE INFORMATION

❑ Check here if you DO NOT have health insurance and you will take full responsibility for medical expenses!

Name of **PRIMARY** insurance: _____Policy/Member ID: _____ Group Number: _____

Address of **PRIMARY** insurance:_____Phone Number:_____

Secondary Insurance: ❑ Yes ❑ No

SECONDARY Insurance: _____ Policy/Member ID: _____ Group Number: _____

Address of **SECONDARY** insurance:_____Phone Number:_____

Responsible Party (if other than you): _____Relationship: _____ DOB: _____

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PATIENT HEALTH INFORMATION

Height: Ft:_____ In:_____ Weight:_____ lbs.

GENERAL HISTORY

(*Please circle the correct answer (YES or NO) and check all boxes with positive answers to the respective question)*

1. Are you allergic to any medications?	YES NO	**If YES**, list all medications: _____
2. Do you currently smoke?	YES NO	If you smoked in the past, when did you quit: _____
3. Do you drink alcohol?	YES NO	**If YES**, for how many years: Number drinks/day ___
4. Have you ever been diagnosed with colorectal cancer?	YES NO	If YES, when was the diagnosis made (date)_____
4a. Did you have colonoscopy(s) performed after diagnosis of colorectal cancer?	YES NO	**If YES**, when was your last colonoscopy _____
5. Do you have a family history (first-degree relatives) of **colon cancer?**	YES NO	**If YES**, check all the relatives with polyps and/or cancer: ❑ Mother, at age ❑ Father, at age ❑ Brother, at age ❑ Sister, at age ❑ Child, at age
5a. Do you have a family member(s) with **colon polyps** removed?	YES NO	Explain:_____

PREVIOUS HISTORY OF COLONOSCOPIES AND ABDOMINAL DISEASES

6. Have you ever had a **full colonoscopy** with sedation? **If YES**, how many colonoscopies? _____ **When did you have your last colonoscopy ____**	YES NO	**If YES**, did you have any complications including: ❑ abdominal pain ❑ fever ❑ nausea/vomiting ❑ bowel perforation ❑ abdominal gas/bloating ❑ rectal bleeding after the procedure ❑ other (describe)

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7. Have you ever had **polyps removed** during colonoscopy?	YES NO	**If YES**, how many times_____ ● Date of last colonoscopy _____ ● How many polyps removed at the last colonoscopy _____ Additional comments:
8. Have you ever been diagnosed and treated for **any cancer of an abdominal organ** (including prostate, ovary, uterus, liver, gallbladder, pancreas, small bowel, stomach, and abdominal lymphoma)?	YES NO	**If YES**, which organ was involved: _____

9. Have you had any of the **abdominal surgeries** listed below:

❑ Cholecystectomy (removal of the gallbladder) ❑ Appendectomy (removal of the appendix)

❑ Hysterectomy (removal of the uterus) ❑ Hernia repair

❑ C-section

❑ Other not listed (please describe briefly) _____

MEDICATIONS YOU CURRENTLY TAKE (Prescribed or Over the Counter) AND PAST MEDICAL HISTORY

10. List **all** the medications you have been taking **within the last two weeks** (including the ones taken on "as needed" basis):

_____

11. Specifically, **within the last week have** you at least taken any of the following blood thinners, diabetes or weight loss medication, if yes, please discontinue filling out forms and call the office to schedule an appointment.

❑ Aspirin, Ibuprofen, Advil, Naprosyn, Voltaren, Aleve or similar anti-inflammatory medications ❑ Coumadin (Warfarin) ❑ Heparin ❑ Lovenox (Enoxaparin) ❑ Plavix (Clopidogrel) ❑ Ticlid (Ticlopidine) ❑ Pradaxa

❑ GLP-1 ❑ Mounjaro ❑ Wegovy ❑ Ozempic ❑ Saxenda ❑ Semaglutide

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12. Have you ever been treated for any of the following disorders:

Asthma	YES NO	Loss of consciousness	YES NO
Diabetes	YES NO	Irregular heartbeat	YES NO
Stroke/TIA	YES NO	Abnormalities in blood clotting	YES NO
Heart attack	YES NO	Crohn's disease or ulcerative colitis	YES NO
Emphysema	YES NO	Seizures	YES NO
Sleep Apnea	YES NO	Hypertension	YES NO
Anemia	YES NO when: _____		

PAST HISTORY OF HEART DISEASES

13. Have you ever had a heart or lung surgery? YES NO

14. Do you have a pacemaker? YES NO

15. Do you have an implanted defibrillator? YES NO

16. Do you have an artificial heart valve? YES NO

17. Have you ever had endocarditis? YES NO

18. If you see any of the following physician(s), please stop filling out forms and call the office to schedule an appointment:

- Cardiologist
- Pulmonologist
- Neurologist
- Nephrologist

19. Have you ever been given antibiotics before dental or surgical procedures? YES NO

20. Have you been diagnosed with Anemia within the past 12 months? YES: when: _____ NO

21. Symptoms: Are you currently experiencing any of the following:

❑ Difficulty swallowing ❑ Abdominal Pain ❑ Diarrhea

❑ Heartburn/Acid Reflux ❑ Change in Bowel Movements and/or habits ❑ Blood in Stool

❑ Nausea/Vomiting ❑ Constipation ❑ Black Stool ❑ Abnormal Weight Loss

PHARMACY INFORMATION

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Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____ City: _____ Zip Code: _____ State: _____

Please, carefully review all your answers above. **If you are uncertain about some of the answers, leave the space blank or place a question mark. You will have the opportunity to clarify these issues later, during a short interview with a member of our staff.** *If you have any questions or additional information you would like to share with us at this time, please write them in the space below.*

PLEASE ATTACH A COPY OF YOUR PICTURE ID AND A COPY OF YOUR INSURANCE CARD

Please carefully read the statement below, and sign and date it at the designated space.

GI GENUS CONSENT

GI Genius is a computer aided machine that is used during your Colonoscopy to help your provider detect polyps that potentially could be missed due to visual limitations. It is $15 at the time of your procedure.
Would you like to add GI Genius to your screening/surveillance Colonoscopy?

_____ Yes
_____ No

Patient Signature Date

Print Name DOB

PATIENT CONSENT AND ACKNOWLEDMENT

I have reviewed the above Pre-Colonoscopy Patient Questionnaire, and I have answered all the questions to the best of my knowledge. I understand that incomplete or false information may result in unexpected complications related to the colonoscopy procedure itself or to the conscious sedation. These complications, which may happen even with your excellent health, may include abdominal pain and bloating, bleeding, bowel perforation, and reaction to medications. I also understand and accept the fact that my colonoscopy may not be completed due to inadequate preparation of the colon, my reactions to the medications used for conscious sedation, or excessive risk for complications as decided by the performing physician before or during the procedure. In such a case, I may choose to have another colonoscopy at different times, or to have barium enema – a radiological procedure (X-ray) during which a liquid contrast material is used to evaluate colon for presence of polyps and cancers. However, barium enema is generally less sensitive for detection of small polyps and masses than colonoscopy, may be uncomfortable, and does not allow removal of detected lesions. Finally, I may choose not to have any follow-up screening procedure and I understand the possible risks of such a decision.

Patient's Signature Print Name Date

I have seen Dr. Radha Tamerisa in the past and she has performed my colonoscopy (circle one): ❑ YES ❑ NO **Once you have completed the following PRE-COLONOSCOPY PATIENT QUESTIONNAIRE, please email to Katyig@drtgastro.com with a copy of your insurance card(s) and driver's license. Or you can mail to:**

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Katy Integrative Gastroenterology
25230 Kingsland Blvd Suite 102
Katy, Texas 77494

We will contact you once our office has received and reviewed your Questionnaire. At that time, we will discuss with you the preparation needed for the procedure, date and possible time of the procedure as well as the location of the endoscopy suite. **If you have any questions, please call the office at 281-869-3009 option 3 for procedure scheduling.**

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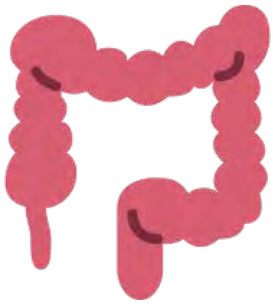
SIGNAL-C™ PROMISE

CLINICAL RESEARCH STUDY

The SIGNAL-C™ test is being developed to detect colorectal cancer (CRC) and advanced precancerous lesions (APL) in average risk screening populations aged 45 and over. We aim to make a CRC detection and prevention test method that is safer, highly accurate, and less invasive.



More than 1.9 million new colorectal cancer cases and 935,000 deaths were estimated in 2020. CRC is the 3rd most commonly diagnosed malignancy and 2nd leading cause of cancer deaths for men and women in the U.S. By 2030, its burden is expected to increase by 60% to more than 2.2 million new cases and 1.1 million deaths.

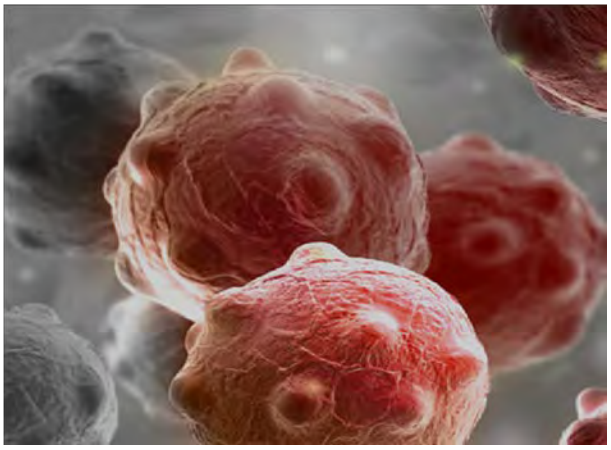
To address the increase in early-onset colorectal cancer cases, both the American Cancer Society and U.S. Preventative Services Task Force have lowered the recommended age for screening individuals at average risk of CRC, from 50 to 45.

YOU MAY QUALIFY IF:

- You are between 45 and 84
- Intended to undergo a standard-of-care screening colonoscopy.
- Willing to consent a blood draw sample
- Up to one year follow up procedure

AND YOU HAVEN'T:

- Undergone colonoscopy within preceding 9 years
- Positive FIT / FOBT within prior 12 months
- Cologuard or Epi proColon within the prior three years
- Had Personal or Family history of colorectal cancer



JOIN US IN OUR FIGHT TO **CURE CANCER**

Universal DIAGNOSTICS
http://www.universaldx.com

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