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, or see Cardiologist, Pulmonologist, Neurologist or Nephrologist—DO NOT FILL OUT THESE FORMS! 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 and sign the consent forms, please email to Katyig@drtgastro.com with a copy of your insurance card(s) and driver's license. Or you can mail to:**

Radha Tamerisa, MD
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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Consent Form

Consent to Treat I hereby authorize Katy Integrative Gastroenterology, PLLC to examine me the patient and to furnish such diagnostic and therapeutic services as they deem necessary and appropriate by today's standards. I authorize and give my consent to Katy Integrative Gastroenterology, PLLC to submit specimens (blood, urine, tissue, etc.) to the laboratory (ies) of choice for analyses and study to include submission for payment to the insurance carrier for the named patient. If I am authorizing on behalf of someone other than myself such examination and services may be provided in my absence.

Assignment of Benefits I hereby allow Katy Integrative Gastroenterology, PLLC to receive payment of insurance benefits for services provided by the doctor, their employees or others working under contract. Any credit balance resulting from benefit payments or other sources may be applied to any other account owed by the patient of the undersigned. Release of Information I authorize release and disclosure of all or any part of my medical record to any person or entity (or representative thereof) which may be responsible to pay for any portion of the charge incurred, including but not limited to any private insurer, government program, workers compensation payer, employer, or family member. I further authorize release to any physicians, hospitals, or others who may require such records in connection with my current or subsequent health care.

I also allow Katy Integrative Gastroenterology, PLLC to obtain medical records from other sources if needed for my medical care. A photocopy of this release shall be considered valid. No person or entity shall be liable for disclosing records in the good faith belief that disclosure is authorized by this release. This release may not be revoked as to any records relating to services provided during this course of treatment.

Advance Beneficiary Notice, many insurance companies will ONLY pay for services that it determines to be "reasonable and necessary". Therefore, certain procedures are excluded from their program. I accept personal responsibility for payment of charges for services rendered to me by Katy Integrative Gastroenterology, PLLC.

I understand as a courtesy, Katy Integrative Gastroenterology, PLLC does file insurance claims for hospital charges and special procedures. However, this does not alleviate my obligation to settle the account in full in the event my insurance company delays or denies the charges. Statement of Ownership Disclosure, in order to allow you to make a fully informed decision about your health care, the physicians of Katy Integrative Gastroenterology, PLLC would advise you, the patient, that he/she may have a financial interest or ownership in one or more of the following healthcare providers: Memorial Hermann Kingsland Surgery Center, Zazen Surgery Center, MD Gastroenterology Anesthesia, Curbside Infusion, and Mangini-Lakhia & Associates.

At some point during your care, medical services, laboratory, pathology, anesthesia or other treatment may be performed by one or more of the providers previously listed.

From time to time, your provider may recommend supplementation based on clinical studies that have shown benefits in certain conditions. You are in no way obligated to utilize the recommended supplements or source or the supplements.

AI Scribe:

We want to assure you that your privacy is our utmost priority. The AI tool adheres strictly to Health Insurance Portability and Accountability Act (HIPPA) compliance guidelines to ensure your data is secured and protected. Ony the healthcare professionals involved in your care will have access to these notes.

These providers may or may not be in-network with your health plan. You have the right to choose the provider of your healthcare services. Therefore, you have the option to use a healthcare provider other than those listed above. You will not be treated differently by your physician if you choose to obtain healthcare services with another provider/facility.

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CONSENT:
I acknowledge that I have discussed, or have had the opportunity to discuss, with my provider(s) the nature and purpose of the consultations and the contents of this Consent Form. I agree to accept the care program on my own free will and I have read the consent form in its entirety. I provide consent for any future consultations or visits required.

PRIMARY CARE PHYSICIAN
Please note that **we are not your primary care physicians**. We recommend that you have a primary care physician. Please do not stop your prescription medications without consulting with your prescribing physician.
I have read the consent form and the above information and I accept the conditions.

Patient Name: _____

Patient Signature: _____

Date: _____

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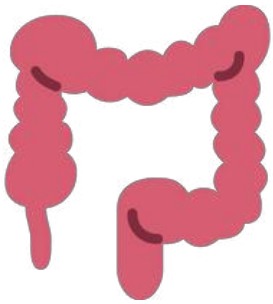
SIGNAL-C™ PROMISE

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.

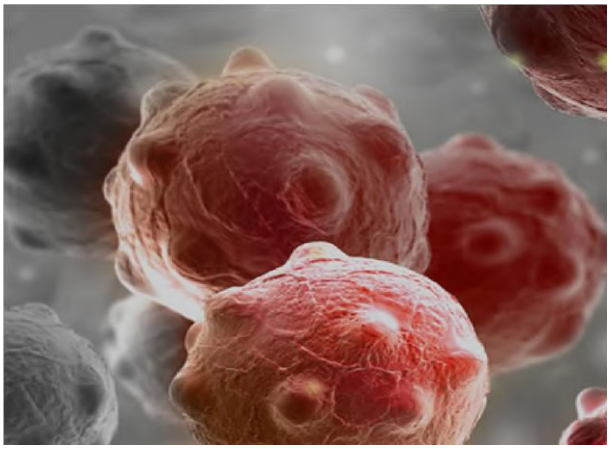
To address the increase in early-onset colorectal cancer cases, both the American Cancer Society and U.S. Preventative Services Task Force have lowered the recommended age for screening individuals at average risk of CRC, from 50 to 45.

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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