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the imaging center at Bend Memorial Clinic PC

VIRTUAL COLONOSCOPY QUESTIONNAIRE

Date _____

NAME			☐ MALE ☐ FEMALE
WEIGHT	HEIGHT	AGE	BIRTHDATE

Date of examination: _____

Reason for the examination:

_____ Screening (I have no symptoms pertaining to the colon)

_____ Diagnostic (I have one or more symptoms pertaining to the colon)

If diagnostic, please list symptoms:

_____

_____

☐ No ☐ Yes Have you ever had a previous colonoscopy? When _____

☐ No ☐ Yes Previous polyp? If yes, type and location _____

☐ No ☐ Yes Family history of colon cancer?

If yes, relative age diagnosed

☐ No ☐ Yes History of recent diverticulitis? *

☐ No ☐ Yes History if inflammatory bowel disease? *

☐ No ☐ Yes History of Crohn's disease? *

☐ No ☐ Yes History of ulcerative colitis? *

☐ No ☐ Yes History of bowel resection, surgery? *

☐ No ☐ Yes Have you ever had cancer? Type _____

☐ No ☐ Yes Have you had any abdominal or pelvic surgery? Type _____

** If you answered "yes" to any the starred questions above, this procedure may not be appropriate for you.*

TO OUR FEMALE PATIENTS:

You must inform the technologist if there is any chance you may be pregnant.

THE REPORT ON YOUR VIRTUAL COLONOSCOPY WILL BE SENT DIRECTLY TO YOUR PRIMARY CARE PHYSICIAN, WHO WILL DISCUSS THE RESULTS WITH YOU.

IF YOU AGREE WITH THIS, PLEASE SIGN THE WAIVER BELOW:

I authorize the release of my report to my primary care physician.

Name of primary care physician: _____

Address: _____

Fax number: _____

X _____

Signature of Patient or Responsible Party Requesting Services Date