COLONOSCOPY QUESTIONNAIRE

I have been informed by Franklin Surgical Associates that I am responsible for obtaining benefit information from my insurance company regarding coverage of colonoscopies. I am aware that insurance companies pay according to their own policies set forth for screening colonoscopies vs diagnostic colonoscopies. I understand I am responsible for informing Franklin Surgical Associates prior to my appointment if I want my colonoscopy billed under my preventative benefits. I understand that I am fully responsible for any and all charges for my colonoscopy that my insurance company may deny or not pay in full.

Patient Name:_____ **Date of birth**:___/___/___

1) Please list any previous colonoscopies you have had, where they were performed and who performed them.
_____
_____

2) If you are an established patient with our practice, please list any surgical procedures you have had since your last visit with us.
_____
_____

3) Please check if you have or have had any of these conditions:
[] Hypertension [] Diabetes [] Kidney Disease [] Heart attack
[] Stroke [] Other, _____

4) List all current medications and dosages:
_____
_____

5) Do you have any problems with your bowels including rectal pain, bleeding, chronic diarrhea, change in bowel habits, constipation? YES / NO **If yes, Please specify:** _____

6) Do you have a personal history of colon polyps or colon cancer? YES / NO
Please circle all that apply. POLYPS / CANCER

7) Do you have a family history of colon polyps or colon cancer? YES / NO
Please Specify: _____

8) Are you currently taking any blood thinners including aspirin? YES / NO
Name of blood thinner:_____

Medications Reviewed By: _____ Blood thinner(s) to be held for ___ days Per Dr. _____.

9) Do you have kidney failure or follow a sodium restricted diet? YES / NO

_____ _____
(Patient Signature) (Date)

****ATTENTION**** All Medicare patients must sign an ABN for "screening & high risk Screening" colonoscopies. This must be signed at time of scheduling the procedure.