Tripler Army Medical Center

Gastroenterology Service Request for Procedure

Thank you for taking time out of your busy schedule to fill out this Patient Assessment. We anticipate that having you complete this at home will enable you to complete it more thoroughly and accurately. Please don't hesitate to call the GI Clinic at (808)-433-1077 if you have any questions or concerns. Our partnership in your care will help ensure the highest quality medical care for you.

Form completed on:

First Name: Last Name:

Prefix/Sponsor last four: / Email:

DOB: (mm/dd/yyyy):

Daytime Telephone: Evening Telephone:

Referring/Primary Care Provider Name: Telephone:

Reason for visit:

Procedure requested: O Colonoscopy O Virtual Colonoscopy

Race: O Caucasian O African-American O Asian Pacific Islander O Hispanic O Unknown O Other

Sex: O Female O Male Height: Feet: Inches Weight: (Pounds)

Female: Have you reached menopause/had a hysterectomy or tubal ligation: O Yes O No

If you are still menstruating we will need to perform a pregnancy test.

Last Education Level: O Grade School O High School O Some College O College Degree O Advanced Degree

Reads/Speaks English: O Yes O No List Primary Language:

Barriers to Care (check all that apply): O None O Cognitive O Language O Cultural O Emotional O Readiness O Other

Barriers to Care Other:

Support System: O Yes O No Preferred Method of Learning: O Seeing O Hearing O Doing O Combo

Limitations (check all that apply): O None O Cane O Walker O Hard of Hearning O Fall History O Glasses

O Contact Lenses O Other Limitations Other:

Aspirin Use: O Yes O No NSAID Use (Advil, Aleve, etc): O Yes O No Anticoagulant Use (Plavix, Coumadin, Heparin, Lovenox, Pradaxa, Refludan, Arixtra, etc.): O Yes O No

Allergies:

Military Pharmacy Used:

Medications: List all including name, dosage, and frequency including over-the-counter products (include vitamins, herbs, anti-inflammatory agensts such as Advil and Tylenol.

Medications:

Medical History (Past and Present)

Previous Colon Cancer Screening (check all that apply): ○ None ○ Flex Sig ○ Barium Enema

○ Virtual Colonoscopy (CTC) Other

Date of last Colonoscopy: ○ None ○ Less than 5 years ago ○ Almost 5 years ago ○ 6-9 Year Ago

○ About 10 years Age ○ Greater than 10 years Age Result of Procedure:

Do you feel you need to be evaluated for any of the following GI symptoms (check all that apply): ○ None

○ Blood in Stool ○ Abdominal Pain ○ Constipation ○ Diarrhea ○ GERD/Heartburn ○ Difficulty Swallowing

○ Unexplained weight loss

Require Pre-Procedure Antibiotics: ○ Yes ○ No

Cardiovascular: Have you ever had a heart attack? ○ Yes ○ No

Pulmonary History (Check all that apply): ○ None ○ Shortness of Breath ○ COPD ○ Asthma ○ Cough ○ Sleep Apnea

(C-Pap: ○ Yes ○ No) Other:

Did you ever smoke? ○ Yes ○ No How many packs/day did you smoke? Have you quit? ○ Yes ○ No

Difficulty with Sedation (please describe):

Do you drink alcohol? Amount (1 can of beer, 1 glass of wine, 1 shot of spirits =1 drink)

○ None ○ <4 drinks/year ○ Up to 3 drinks/week ○ 4-13 drinks/week ○ 14 or more drinks/week

Do you have a parent or sibling who had colon cancer or rectal cancer? ○ Yes ○ No

If yes, then please put relationship and age of their diagnosis?

Please add any comments: