MEDICAL HEALTH QUESTIONAIRE – VIRGINIA COLONOSCOPY AND CENTER FOR HEALTH
DR. KEITH BERGER AND DR. BETH JAKLIC | PH: (757) 412-4919 FAX: (757) 412-4898

Patient's Name: ________________________ DOB: ___________

Reason for Visit

Reason Referred: ☐ Colonoscopy ☐ Colo & EGD ☐ E-Visit ☐ Consultation ☐ Weight Loss ☐ EGD

☐ Yes ☐ No Are you experiencing any of the following?
☐ Diarrhea ☐ Chest pain ☐ Indigestion
☐ Change in bowel habits ☐ Anemia ☐ Difficulty swallowing
☐ Blood in stool ☐ Persistent heartburn ☐ Prostate issues
☐ Abdominal pain ☐ Positive Occult Stool Test ☐ Positive Cologuard
☐ Chronic Constipation

If yes, please explain: ________________________________

Patient Preferences

Pharmacy: ________________________Ph. # ______________
Lab: ______________________________Ph. # ______________
PCM: _____________________________Ph. # ______________
Referring MD: ____________________ Ph. # ______________
Other Providers: __________________ Ph. # ______________
____________________ Ph. # ______________

Allergies

☐ Yes ☐ No Drug, food, iodine, shellfish, latex, or any other allergies?
Allergies: ____
Reactions: ____

Medication List:

	Name	Dose	How Often
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Family History

☐ Yes ☐ No Family Hx of gastrointestinal cancers, colon polyps, rectal cancer, or IBD?
Who? ______________________ Age of Onset? __________
☐ Yes ☐ No Family Hx of stomach, esophageal, or rectal cancer?
Explain: ____

Problems

☐ Yes ☐ No Antibiotics prior to procedure?
☐ Yes ☐ No Any bleeding problems?
☐ Yes ☐ No Currently pregnant?
☐ Yes ☐ No Diabetic?
☐ Yes ☐ No Do you take insulin?
☐ Yes ☐ No Heart problems?
☐ Leaking or artificial heart valve ☐ Pacemaker/Internal defibrillator
☐ High blood pressure ☐ Murmurs
☐ Mitral valve prolapse
If yes, please explain: ________________________________
☐ Yes ☐ No Stroke?
☐ Yes ☐ No BMI > 35? HT _____ WT _____ BMI ____

☐ Yes ☐ No Kidney Problems?
If yes, please explain: ________________________________

☐ Yes ☐ No Lung/Breathing problems
☐ Sleep apnea ☐ COPD ☐ Emphysema
☐ Asthma ☐ CPAP Device
If yes, please explain: ________________________________

☐ Yes ☐ No Exposure to contagious diseases?
☐ HIV ☐ TB ☐ Hepatitis B
☐ Covid-19 ☐ Hepatitis C

☐ Yes ☐ No Have you been in contact with anyone that has tested positive for Covid-19 or believes that they have it?
Who? ______________________ When? _____________________
☐ Yes ☐ No Have you traveled anywhere in the last month? Where? ______________________
☐ Yes ☐ No Have you had a fever, chills, or ANY cold or flu-like symptoms in the past two weeks?

☐ Yes ☐ No Prior endoscopy or colonoscopy?
When? _______Where? _________ Who performed? ___________
Results: ____
☐ Yes ☐ No Any previous colonoscopy/anesthesia complications?
Explain: ____
☐ Yes ☐ No Any problems with previous colonoscopy prep?
Explain: ____

☐ Yes ☐ No Taking any blood thinners?
☐ Coumadin ☐ Eliquis ☐ Pradaxa ☐ Xarelto
☐ Other ____
☐ Yes ☐ No Taking any platelet inhibitors?
☐ Plavix ☐ Dipyridamole ☐ Aspirin ☐ Other ______________
☐ Yes ☐ No Do you take NSAID's?
☐ Ibuprofen ☐ Aleve ☐ Motrin ☐ Other __________________

☐ Yes ☐ No ☐ Quit – When? ______ ☐ Smoke tobacco?
If yes, how much/how long? ________________________________
☐ Yes ☐ No ☐ Do you drink alcohol?
How much? ___________________ per day/ per week (circle one)

Surgical History

Dates	Diagnosis/Procedure Done	M.D.
______	________________________________	____________
______	________________________________	____________
______	________________________________	____________
______	________________________________	____________

Past Medical History

☐ Yes ☐ No Barrett's esophagus?
☐ Yes ☐ No Bleeding disorder?
☐ Yes ☐ No Breast cancer?
☐ Yes ☐ No Crohn's disease?
☐ Yes ☐ No Diverticulitis/Diverticulosis? (circle one)
☐ Yes ☐ No GERD/Reflux?
☐ Yes ☐ No Ulcerative colitis?

Please do not write in this box -- for staff notes only

Staff Initials: _______ Date: ________Clearances needed? ________