



Digestive Disease Consultants

powered by



*****PLEASE FILL OUT ENTIRE FORM*****

Patient's Name: _____ TODAY'S DATE: _____

Date of Birth (DOB): _____ Current Age: _____ Sex: MALE FEMALE

Address: _____ City, State & Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: Single Married Separated Divorced Widowed SSN: _____

Family Doctor/PCP: _____

Referring Doctor: _____

Pharmacy: _____

Mail Order Pharmacy: _____

May we leave a message: On your voicemail/answering machine No Yes Via Text Message: No Yes

Via Email No Yes If yes, email address: _____

Employer: _____

WHO CAN WE SPEAK TO REGARDING YOUR MEDICAL CONCERNS / HISTORY?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

EMERGENCY CONTACT: (phone # must be different than patient's phone #)

Name: _____ Phone #: _____ Relationship: _____

Responsible Party for Insurance & Medical Bills: Patient Spouse Parents Mother Father Other

Primary Insurance Company: _____

Subscriber Name: _____ Subscriber DOB: _____

Insurance ID #: _____ Insurance Group #: _____

Relationship to Card Holder: Self Spouse Dependent Co-Payment: \$ _____

Secondary Insurance Company: _____

Subscriber Name: _____ Subscriber DOB: _____

Insurance ID #: _____ Insurance Group #: _____



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PLEASE COMPLETE THIS QUESTIONNAIRE WITH UPDATED INFORMATION & RETURN TO OUR OFFICE

Date: _____ Last Name of Provider at Digestive Disease Consultants: _____

Patient Name: _____ DOB: _____

Address: _____

Best Phone # to Reach You: HOME _____ CELL _____

Name of Family Doctor / PCP: _____

Medical Questionnaire:

- **Current Weight:** _____ **Height:** _____
- **Since your last visit with one of our providers, have you had any major health changes such as heart problems, stroke, lung problems, or major surgery?** Yes No (If yes, please list) _____

- **Are you on any blood thinners?** Yes No (If yes, please list): _____
(Examples: Coumadin, Heparin, Plavix, Vitamin E, Pradaxa, Eliquis, Xarelto, Brilinta, Warfarin)
 - **Name of Doctor Managing Blood Thinners** _____
- **Do you have an Internal Defibrillator or Pacemaker?** Yes No
- **Are you taking Ozempic, Mounjaro, Wegovy, or any similar GLP-1 Medications?** Yes No
(If yes, please list) _____
- **Are you taking Aspirin?** Yes No
- **Are you taking Iron Supplements?** Yes No
- **Have you ever had any significant reactions or allergies to anesthesia?** Yes No (If yes, please list): _____

- **Are you currently experiencing rectal bleeding, unexplained weight loss, ongoing abdominal pain, or changes in bowel habits?** Yes No
- **Have you had a positive stool test recently?** Yes No
- **Since your last colonoscopy, have you been told you had an inadequate prep or was unable to complete your prep?**
 Yes No

If you are on the above medications, **you may need to discontinue prior to your procedure**

Once your paperwork has been received and reviewed by your provider, WE WILL CONTACT YOU TO SCHEDULE.

