Brenda J. Jobson, D.O.
154 Bogle Office Park Drive, Suite B
Somerset, KY 42503
Phone: 606-676-0110
Fax: 606-676-0107

LAKE CUMBERLAND
Gastroenterology

Open Access Colonoscopy Patient Questionnaire

First Name_______________________ M.I._____ Last Name ___________________________

Sex ☐ M ☐ F DOB_______________ SSN___________________________

Marital Status ___________________ Race____________Preferred Language_______________

Height __________________ Weight ____________Employer_____________________________

Mailing Address ____

Billing Address ____

County_________________________ Email Address ____________________________________

Home Phone ___________________ ☐Work Phone _________________________☐

Cell Phone____________________ ☐(Please check best contact number)

Emergency Contact

Name______________________________ Relationship _____________ Phone_______________

Referring Physician

Name____________________________________ Phone ___________________________________

Primary Care Physician

Name____________________________________ Phone ___________________________________

Cardiologist

Name____________________________________ Phone ___________________________________

Preferred Pharmacy

Name____________________________________ Phone ___________________________________

Address ___________________________________ City ___________________________________

Primary Insurance

Name of Insurance __________________Precertification Phone___________________________

Claim Address____

Policy Number ___________________________ Group Number___________________________

Policy Holder's Name ________________________ Relationship___________________________

SSN ___________________________DOB _____________Employer_________________________

LAKE CUMBERLAND
Gastroenterology

Secondary Insurance

Name of Insurance __________________ Precertification Phone ___________________________

Claim Address ____

Policy Number ___________________________ Group Number ___________________________

Policy Holder's Name ________________________ Relationship ___________________________

SSN ___________________________ DOB _____________ Employer ________________________

☐ Check here if uninsured and would like to discuss payment options.

Do you have persistent or recurring problems, or a history of the following?

Is this your first colonoscopy?	☐ Yes	☐ No
Has it been 10 years since your last colonoscopy?	☐ Yes	☐ No
Are you on any blood thinners?	☐ Yes	☐ No
Have you recently had a physical exam?	☐ Yes	☐ No
Are you a dialysis patient?	☐ Yes	☐ No
Do you have congestive heart failure?	☐ Yes	☐ No
Do you have ischemic heart disease?	☐ Yes	☐ No

General:

☐ Dizziness ☐ Fatigue ☐ Fever ☐ Wheelchair Bound

☐ Unexplained Weight Loss ________lbs ☐ Unexplained Weight Gain _________lbs

Timeframe of weight change: ____

GI:

☐ Abdominal Pain ☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Heartburn/Reflux
☐ Difficulty/Painful Swallowing ☐ Vomiting ☐ Rectal Bleeding/Blood in Stool
☐ Ulcerative Colitis ☐ Crohn's ☐ Liver Disease
☐ Intestinal Surgery in the last 6 months (what & when)___________________________________
Have you ever had a colonoscopy? ☐ Y ☐ N When? Where?_________________________________
Have you ever had polyps or colon cancer? ____
Any relatives with colon cancer/polyps? Who and what age were they?______________________

____

Hematologic:

☐ Anemia (recent treatment) ☐ Free Bleeder/Hemophiliac
☐ Take any Blood Thinners, such as Plavix, Coumadin, Warfarin, Effient, Lovenox, etc.

Neurologic:

☐ Stroke/TIA - when?___________Do you have any weakness leftover? ______________________
☐ Seizure - when was your last one?____

Cardiovascular:

☐ Chest Pain/Pressure/Heaviness ☐ Irregular Heart Rhythm ☐ High Blood Pressure
☐ Bypass - When? ___________ ☐ Valve Surgery ☐ Heart Attack/MI - When? ____________
☐ Stents Placed - When? ___________

☐ Defibrillator and/or Pacemaker - What kind? ____

☐ Congestive Heart Failure - When? ____

ENT (Ear, Nose, Throat):

☐ Hard of Hearing ☐ Unexplained Vision Changes ☐ Glaucoma

Genitourinary:

☐ Kidney disease/failure ☐ Diabetes ☐ Insulin ☐ Oral Medications

☐ Dialysis - What kind: ____

Psychological:

☐ Depression ☐ Anxiety/Panic Attacks ☐ Dementia/Memory Loss

☐ Other Mental Illness - What kind? ____

Respiratory:

☐ Sleep apnea ☐ Shortness of Breath ☐ Asthma (recent treatment)
☐ COPD/Emphysema/Chronic Bronchitis

☐ On Oxygen - How many liters and when? ____

Other Medical History:

____

____

____

Previous Surgeries and Dates:

1.	4.
2.	5.
3.	6.

Social History:

Occupation:________________________________ Number of Children: ________________

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

Alcohol:

☐ Beer How much?_________ How many? _______ How often? __________
☐ Wine How much?_________ How many? _______ How often? __________
☐ Liquor How much?_________ How many? _______ How often? __________

Tobacco:

☐ Chew/Dip ☐ Current Smoker ☐ Former Smoker ☐ Never Smoker

Packs per day: ____

Drug Use:

☐ I have never used recreational drugs ☐ I have used recreational drugs in the past
☐ I currently use recreational drugs ☐ I have been treated for substance abuse

Allergies to Medications, Foods, or Latex:

NAME	REACTION
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Family History:

☐ Colon Cancer Who? ________________ Age when diagnosed?_________
☐ Colon Polyps Who? ________________ Age when diagnosed?_________
☐ Inflammatory Bowel Disease Who? ________________ Age when diagnosed?_________
☐ Other___________________ Who? ________________ Age when diagnosed?_________

Medications:

NAME	DOSAGE	HOW OFTEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		

Additional information (such as additional allergies, additional medications, etc.):

I understand that if I have not answered these questions honestly and to the best of my knowledge, it could result in complications during my procedure.

Digital Patient Acknowledgment:______________________________**Date:** _______________
(Please type your name for Digital Patient Acknowledgment)

Patient Signature:____**Date:** _______________
(To be signed in person the day of your screening.)

Completed forms may be printed and returned to:
Lake Cumberland Gastroenterology
154 Bogle Office Park Drive, Suite B
Somerset, KY 42503

Or by fax to: 606-676-0107

Or the digital form may be emailed to: LCGastro@lpnt.net