



Frederick Gastroenterology Associates

310 West Ninth Street, Frederick Maryland 21701

Open Access Colonoscopy Questionnaire

Patient Name:	Date of Birth:	
Address:		
City:	State:	Zip code:
Telephone Number:	Email address:	
PLEASE ANSWER THE QUESTIONS BELOW TO DETERMINE IF YOU ARE A CANDIDATE FOR OPEN ACCESS COLONOSCOPY.		
Have you had a heart attack or stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had unexplained chest pain or shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a heart valve disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had a heart stent placed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have an implanted pacemaker, defibrillator or nerve stimulator?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had congestive heart failure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had kidney failure or dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you take insulin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you require supplemental oxygen at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you weigh over 250 pounds (Women): 300 pounds (Men)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have an alcohol or chemical dependency?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you felt ill over the past two weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you regularly taking any prescription pain medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please check any medications on the list below that you are currently taking.		
<input type="checkbox"/> Anagrelide (Agrylin)	<input type="checkbox"/> Argatroban (Acova)	<input type="checkbox"/> Fondaparinux (Arixtra)
<input type="checkbox"/> Ticagrelor (Brilinta)	<input type="checkbox"/> Warfarin (Coumadin)	<input type="checkbox"/> Prasugrel (Effient)
<input type="checkbox"/> Apixaban (Eliquis)	<input type="checkbox"/> Clopidogrel (Plavix)	<input type="checkbox"/> Cilostazol (Pletal)
<input type="checkbox"/> Dabigatran (Pradaxa)	<input type="checkbox"/> Ticlopidine (Ticlid)	<input type="checkbox"/> Rivaroxaban (Xarelto)
<input type="checkbox"/> Vorapaxar (Zontivity)		

If you answered "YES" to any of the above questions, please contact our office at 301-695-6800 to schedule your pre-procedure office visit.

If all your answers are "NO" mail this form to the office or fax to 301-695-6891.