Jordan & Associates
GASTROENTEROLOGY, P.A.

Christopher P. Jordan, M.D.

Jordan Digestive Diagnostic Center, 649 Guy Road, Clayton, NC 27520
Phone: 919-938-4404 | Fax: 919-938-3055

COLON SCREENING FORM

Please help us serve you in the most efficient and effective manner by completing this medical history form. Please fax or deliver it with your insurance card prior to your telephone colon screening appointment. Directions and fax number (919-938-3055) are included in your screening colonoscopy pamphlet.

Name:______________________________ Address: _________________________________

Date of Birth:________________________ _________________________________

Phone Number:_______________________ Weight:________Height:_____________________

Allergies

Medicine	Reaction	Medicine	Reaction

Are you allergic to Latex? ☐ YES ☐ NO

Are you allergic to Eggs? ☐ YES ☐ NO

Are you allergic to Peanuts? ☐ YES ☐ NO

Medications

Prescription and over the-counter (including vitamins, herbs, and supplements: use additional paper if needed)

Name	**Dose**	**Frequency**
Example: xxxxxxxxxxxx	81 mg	1 in the morning

Medical History: [Please check (√)] if you have/had and comment in space provided)

☐	BLINDNESS	☐	CATARACTS	☐	GLAUCOMA
☐	HEARING LOSS	☐	DIZZINESS	☐	STROKE
☐	MINI-STROKE	☐	HIGH BLOOD PRESSURE	☐	ANXIETY
☐	DEPRESSION	☐	CANCER	☐	HEPATITIS
☐	CIRRHOSIS	☐	IRRITABLE BOWEL	☐	HYPOTHYROIDISM
☐	KIDNEY FAILURE	☐	DEFIBRILLATOR	☐	BLOOD CLOT
☐	ANEURYSM	☐	CONGESTIVE HEART FAILURE	☐	HEART DISEASE
☐	MITRAL VALVE PROLAPSE	☐	HEART ATTACK	☐	HIGH CHOLESTEROL

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☐	LEAKY HEART VALVE	☐	ANGINA	☐	HEART MURMUR
☐	IRREGULAR HEARTBEAT	☐	PACEMAKER	☐	ASTHMA
☐	RHEUMATIC FEVER	☐	DIABETES	☐	MULTIPLE SCLEROSIS
☐	EMPHYSEMA	☐	PNEUMONIA	☐	CROHN'S DISEASE
☐	ULCERATIVE COLITIS	☐	STOMACH ULCER	☐	HIATAL HERNIA
☐	CELIAC DISEASE	☐	PANCREATITIS	☐	BARRETT'S ESOPHAGUS
☐	COLON POLYPS	☐	COLON CANCER	☐	KIDNEY DISEASE
☐	DIALYSIS	☐	ARTHRITIS	☐	FIBROMYALGIA
☐	MIGRAINES	☐	SEIZURES	☐	ANEMIA
☐	OTHER:				

Comments: (Type of **cancer** and any other important related information:

Have you ever had problems with anesthesia? ☐ YES ☐ NO **(**DESCRIBE):________________________

Surgical History [Please check (√) if you have had the following]

☐	GALLBLADDER SURGERY	☐	APPENDECTOMY	☐	TUBAL LIGATION
☐	HYSTERECTOMY	☐	D&C	☐	CESAEREAN SECTION
☐	CATARACT (R OR L)	☐	LAPAROSCOPY	☐	HEART VALVE REPLACEMENT
☐	NISSEN FUNDOPLICATION	☐	COLONOSCOPY	☐	UPPER ENDOSCOPY
☐	PROSTATE SURGERY	☐	KNEE REPLACEMENT (R OR L)	☐	ROTATOR CUFF REPAIR (R OR L)
☐	THYROIDECTOMY	☐	PILONIDAL CYST	☐	TONSILLECTOMY
☐	COLORECTAL SURGERY				
☐	OTHER:				

FAMILY HISTORY: [PLEASE (√) IF APPLICABLE

[√]	MEDICAL CONDITION	FAMILY MEMBER	[√]	MEDICAL CONDITION	FAMILY MEMBER
☐	COLON CANCER AGE___		☐	HIGH BLOOD PRESSURE	
☐	COLON POLYPS		☐	CONGESTIVE HEART FAILURE	
☐	CROHN'S DISEASE		☐	HEART ATTACK	
☐	ULCERATIVE COLITIS		☐	CIRRHOSIS	
☐	STROKE		☐	HEART DISEASE	
☐	HEPATITIS		☐	EMPHYSEMA	
☐	ASTHMA		☐	OVARIAN CANCER	
☐	GARDNER'S SYNDROME		☐	BREAST CANCER	
☐	DIABETES		☐	LUNG CANCER	
☐	UTERINE CANCER		☐	LIVER CANCER	
☐	PROSTATE CANCER		☐	PANCREATIC CANCER	
☐	OTHER:				

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Social History [PLEASE CHECK(√) IF APPLICABLE AND GIVE USAGE

[√]	PRODUCT AMOUNT USED	[√]	PRODUCT AMOUNT USED	[√]	PRODUCT AMOUNT USED
☐	CIGARETTES ________	☐	DAILY BEER: _________	☐	CHEWING TOBACCO ______
☐	DAILY WINE ________	☐	SNUFF _________	☐	DAILY WHISKEY _______
☐	CIGARS ________	☐		☐	

DAILY ILLEGAL DRUGS: TYPE:________________________FREQUENCY:__________________________

PLEASE CHECK (√) IF YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING:

[√]		[√]		[√]	
☐	LOSS OF APPETITE	☐	FEVER	☐	SKIN RASH
☐	NECK PAIN	☐	STIFF NECK	☐	CHANGE IN SKIN COLOR
☐	SWOLLEN GLANDS	☐	VISION PROBLEMS	☐	DEAFNESS
☐	HOARSENESS	☐	ABDOMINAL PAIN	☐	DIARRHEA
☐	BLACK TARRY STOOLS	☐	RECTAL BLEEDING	☐	CONSTIPATION
☐	NAUSEA	☐	VOMITING	☐	BLOOD IN YOUR STOOL
☐	ABDOMINAL CRAMPS	☐	DIFFICULTY SLEEPING	☐	ABDOMINAL DISTENTION
☐	ABDOMINAL BLOATING	☐	PAINFUL BOWEL MOVEMENTS	☐	DIFFICULT SWALLOWING
☐	WEIGHT LOSS	☐	HEADACHES	☐	SEIZURES
☐	FAINTNG SPELLS	☐	LOSS OF CONSCIOUSNESS	☐	ANEMIA
☐	PROLONGED BLEEDING	☐	EASY BRUISING	☐	JOINT PAIN
☐	JOINT STIFFNESS	☐	JOINT REDNESS	☐	HIGH BLOOD PRESSURE
☐	SWELLING	☐	CHEST PAIN	☐	DIFFICULTY BREATHING
☐	DEPRESSION	☐		☐	

PLEASE CHECK[√] THE TERMS THAT BEST DESCRIBE YOUR BOWEL MOVEMENTS:

[√]		[√ [		[√]		[√]	
☐	NORMAL CONSISTENCY	☐	BLACK& TARRY	☐	BLACK	☐	SOFT
☐	MIXED WITH BLOOD & MUCUS	☐	LIQUID/PASTY	☐	SEEDY	☐	GREEN
☐	FOUL SMELLING	☐	HARD/FIRM	☐	PELLET	☐	YELLOW
☐	FLOATS ON WATER	☐	WATERY	☐	BROWN	☐	BLOODY

How many bowel movements do you have a day? ___________

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PREVIOUS EVALUATIONS AND GIVE DATE (PLEASE CHECK [√] PREVIOUS EVALUATIONS

[√]		[√]		[√]	
☐	BARIUM ENEMA (YEAR) ______	☐	FLEX SIGMOIDOSCOPY (YEAR) ______	☐	UPPER ENDO (YEAR) ______
☐	PROCTOSCOPY (YEAR) ______	☐	COLONOSCOPY (YEAR) ______	☐	CAPSULE ENDO(YEAR)_____

Have you ever been told you needed an antibiotic prior to an invasive procedure? _______YES ______NO

If so please explain. ____

Who will be driving you home after your procedure? ____

Please leave all jewelry and valuables at home the day of your procedure.

SIGNATURE:_______________________________ DATE:________________________________