Patient's Name : _____ DOB:_____ Age_____

Telephone:(C)_____ (H)_____Email:_____

Address:_____Primary Language:_____

All referrals must be thoroughly screened before submitting to the doctors. All documentation should be attached including past procuders, pathology and clo tests.

1. Are you experiencing any stomach issues: Yes ☐ No ☐

   Diarrhea ☐ Constipation ☐ Rectal Bleed ☐ Abdominal Pain ☐

   Less than 5 bowel movements a week ☐

   Other Gl Symptomps_____

2. Have you had a colonscopy? Yes ☐ No ☐

3. How long ago? _____

4. If not at CVG where _____

5. Please bring medical records.

6. Do you have a personal or family history of colon cancer? Yes ☐ No ☐

   if yes, who and what stage_____

7. Do you have heart problem? Yes ☐ No ☐ if yes , what_____

8. Blood thinners? Yes ☐ No ☐ if yes,which_____

9.Pacamaker/Defibrillator circle if applicable

10. Do you have any of the following:

    Are you under Dialysis treatment: Yes ☐ No ☐

    Oxygen dependent: Yes ☐ No ☐ Congestive Heart Failure: Yes☐ No☐

    Other: _____

Must check hospitals for past colonscopies

GDDI, Citrus Valley/QVH/ICMC/Foothill

San Dimas Hospital Initials_____ Date_____