

Conejo Gastroenterology – Gastroenterology/Hepatology & Advanced Therapeutic Endoscopy

PATIENT REGISTRATION

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|--|--|-----------------------------------|--|--------------------------------|---|---|---|---|
| Today's date: | | | | Primary Care Physician: | | | | |
| PATIENT INFORMATION | | | | | | | | |
| Last name: | | First: | | Middle: | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss <input type="checkbox"/> Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid | |
| Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No | If not, what is your legal name? | | | (Former name): | | Birth date: / / | Age: | Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
| Street address: | | | | | | Home phone #: | | |
| City: | State: | | | ZIP Code: | | Cell phone #: | | |
| Occupation: | | Email Address: | | | | Would you like email reminders and web portal access? (circle one) Yes No | | |
| Chose clinic because/Referred to clinic by (please check one box): | | | | <input type="checkbox"/> Dr. | | <input type="checkbox"/> Insurance Plan | <input type="checkbox"/> Hospital | |
| <input type="checkbox"/> Family/Friend | <input type="checkbox"/> Advertisement | <input type="checkbox"/> Internet | | Advanced Directives | | Yes | No | |
| Patient/Guardian signature: | | | | | | Date: | | |

OPEN ACCESS COLONOSCOPY QUESTIONNAIRE

We have developed a program which allows for healthy individuals to schedule screening colonoscopy without need for an office visit before the procedure. If your physician has suggested, you have a colonoscopy you may qualify for this program. Of course, not all patients will be able to safely undergo colonoscopy without a more detailed evaluation of their health history and their risks for the procedure. If that is the case for you, please call our offices and we will schedule an appointment so the physician can review your medical history, assess your current condition and determine how to best meet your health needs.

Please complete the following questions and attached forms and return to our office via mail or fax (805-449-4277) or email: thousandoaksgastro@gmail.com We will contact you in 5-7 business days.

1. How old are you? _____

2. What is your height? _____ What is your weight? _____

3. Have you had a colonoscopy in the past?
 - a. If yes, when and where?

 - b. What were the results? Were there polyps present?

 - c. Do you have any first-degree relatives with colon cancer?
(mother/father/brother/sister?)
 - a. If yes, who and what age were they when diagnosed?

4. Why did your doctor suggest a colonoscopy?

5. Do you have any gastrointestinal symptoms? *(Please circle one)*
 - a. Abdominal pain
 - b. Bleeding
 - c. Weight loss
 - d. Diarrhea or constipation
 - e. Change in bowel habits or caliber
 - f. Anemia
 - g. NONE OF THE ABOVE

6. What pharmacy do you use? _____

7. Do you have any of the following medical problems?

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- a. History of heart disease, heart attack, or endocarditis
 - b. Heart valve replacement
 - c. Pacemaker/Defibrillator/Stent
 - d. On anticoagulation therapy (Coumadin, Plavix, Heparin, Ticlid, Lovenox, Eliquis, Pradaxa, Xarelto, or others)
 - e. Renal failure or on dialysis
 - f. History of chronic pulmonary problems (chronic asthma, emphysema, COPD, sleep apnea)
 - g. Joint replacement within 2 months
 - h. Mobility problems, paralysis, stroke, Parkinson's, TIA
 - i. History of diabetes
 - j. Weight > 350
 - k. Organ transplant
 - l. Alcohol or drug dependency
 - m. Currently smoking
 - n. History of obesity surgery
 - o. NONE OF THE ABOVE
8. Are you taking any weight loss medications? (Ozempic, Wegovy, Semglutide, Zepbound, others)
9. Any history of anesthesia problems?
10. Are you able to walk without assistance?
11. Any allergies to medications?
12. List all your medications below (or add separately):

Please return: fax (805-449-4277), email (thousandoaksgastro@gmail.com) or mail the following forms:

1. Open access colonoscopy questionnaire
2. Driver's license
3. Insurance
4. Missed appointment and procedure policy form

Mail to: Kumar Desai, MD, 227 W. Janss Road, Suite 125, Thousand Oaks CA 91360

PATIENT ACKNOWLEDGEMENT FORM

- I have reviewed the Open Access Colonoscopy Questionnaire and have answered all the questions truthfully to the best of my knowledge.
- Open access colonoscopy is designed to allow healthy, age-appropriate patients to have a screening colonoscopy without an office visit. The questionnaire that I have completed will be carefully reviewed and I may be called for points of clarification. For my safety, depending on the answers provided, I understand I may be scheduled directly for a screening colonoscopy or if I do not meet open access criteria, an office visit will be scheduled.
- I understand that by choosing to pursue Open Access Colonoscopy I have not, nor during this process will I have, a GI consultation. I understand that I have the choice to make an appointment for an office visit to discuss colonoscopy and have declined to do so. I also understand that I will require a separate office visit to address any GI complaints I may have.
- If I am scheduled directly for a screening colonoscopy information is included regarding preparation for the procedure, the procedure itself, and post-procedure concerns. I will read the information provided and make sure that I understand and will be able to comply with the instructions given.
- I understand that, while not likely, there are risks involved with colonoscopy as with any medical procedure. These risks are outlined in the information that I have received. I have reviewed this information to my complete satisfaction, and I understand the risks and the benefits of colonoscopy.
- Should I have any changes in my health status or insurance after being scheduled or have any questions about the information I receive by mail, I will call 805-449-4278.
- I understand that I must have someone drive me to the procedure and drive me home. Without a designated driver the procedure will be cancelled.

Patient Name _____ Date of Birth _____

Patient Signature _____ Date _____