New York Private Medical Imaging LLP

VIRTUAL COLONOSCOPY SCREENING SHEET

COMPLETED BY PATIENT

PATIENT NAME: DATE:

DATE OF APPOINTMENT: / / DATE OF BIRTH: / / AGE:

REFERRING PHYSICIAN: PHONE #:

Reason for exam:

Previous Polyp?	☐YES ☐NO	If YES, explain:
Previous Colon Cancer?	☐YES ☐NO	If YES, explain:
Family history of Colon Cancer?	☐YES ☐NO	If YES, explain:
If YES, what age?		
History of Inflammatory bowel disease?	☐YES ☐NO	If YES, explain:
History of Crohn's disease?	☐YES ☐NO	If YES, explain:
History of ulcerative colitis?	☐YES ☐NO	If YES, explain:
History of bowel resection?	☐YES ☐NO	If YES, explain:
History of bowel surgery?	☐YES ☐NO	If YES, explain:

Technologist comments:

Radiologist:

Technologists initials:

SCREENED BY: SCREENED WITH:

I verify that the answers I have provided to questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam.

Patients signature: Date: / /