Main Line HealthCare
Physician Network

SURGICAL ASSOCIATES
COLONOSCOPY QUESTIONNAIRE

PLEASE HELP US TO HELP YOU SCREEN FOR COLON AND RECTAL CANCER.

NAME: _____ **DATE:** _____
YOUR AGE/DATE OF BIRTH: _____

Please check any symptoms that you have had since we last saw you:

- ☐ Change in bowel habits
- ☐ Bleeding with bowel movements or rectal bleeding
- ☐ Hemorrhoids
- ☐ Narrow stools
- ☐ Fatigue
- ☐ Weight loss
- ☐ Decreased appetite
- ☐ Rectal or abdominal pain
- ☐ Anemia

FAMILY HISTORY

Do any of your FAMILY MEMBERS, (including parents, siblings, aunts, uncles, grandparents, or your children), have a history of COLON CANCER or COLON POLYPS? Please check where appropriate and specify which family member:

- ☐ Colon cancer _____
- ☐ Rectal cancer _____
- ☐ Colon polyps _____

Do any of your FAMILY MEMBERS (including parents, siblings, aunts, uncles, grandparents, or your children), have a history of OTHER CANCER? WHO and WHAT TYPE OF CANCER:

_____

_____

PERSONAL HISTORY

Have YOU ever had colon or rectal POLYPS or CANCER:

- ☐ No
- ☐ Yes: WHEN? _____

Do YOU have a history of Inflammatory Bowel disease, such as Ulcerative Colitis:

- ☐ No
- ☐ Yes: WHEN? _____

Date of last colonoscopy: _____
Physician's name who completed Colonoscopy: _____