

PARK WEST RADIOLOGY

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: / /