



Colonoscopy Request and Intake Form

Complete all sections; write "none" or "N/A" when appropriate.

Attach insurance cards, a current medication list, and prior colonoscopy or relevant test reports.

Patient information

Full name _____ Date of birth _____ Gender _____
Address _____ City / State / ZIP _____
Phone _____ Email _____ Preferred Language _____
Emergency contact/relationship _____
Phone _____

Reason for colonoscopy and referral

Check all that apply:

- ☐ Screening
- ☐ Prior polyps/cancer
- ☐ Family history of colorectal cancer
- ☐ Positive stool test
- ☐ Rectal bleeding
- ☐ Anemia
- ☐ Change in bowel habits
- ☐ Other _____

Symptoms/duration or details _____

Last colonoscopy date/location _____ Findings _____

Family history: relative/diagnosis/age at diagnosis _____

Referral source / provider _____ Phone / fax _____

Medical history and care team

Medical problems/prior surgeries (or attach list) _____

Check if applicable:

- ☐ Heart disease
- ☐ Stroke
- ☐ Lung disease/home oxygen

- ☐ Sleep apnea/CPAP
- ☐ Diabetes
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Pacemaker/defibrillator
- ☐ Bleeding disorder

Prior anesthesia problems _____ Possible pregnancy? ☐ Yes ☐ No ☐ N/A

PCP name/phone _____

Cardiologist name/phone _____

Pulmonologist/other specialist name/specialty/phone _____

Medications and allergies

List all medications and doses, including supplements, or attach a list: ☐ List attached ☐ None

Taking: ☐ Blood thinners/aspirin ☐ Insulin/diabetes medications ☐ GLP-1 medicines (e.g., Ozempic)

Allergies and reactions (including medicines/latex) _____

Insurance and scheduling

Primary insurer _____ Member ID _____ Group _____

Policyholder name / DOB/relationship _____

Secondary insurer/member ID _____

Preferred days _____ Adult available to drive you home? ☐ Yes ☐ No

Completed by/relationship _____ Date _____

FOR OFFICE USE Insurance verified ☐ Authorization ☐ Required ☐ Not required

Medical clearance ☐ Required ☐ Not required Reviewer _____ Confirmed date _____