Dr. Kovacev Endoscopy Questionnaire

Name: _____ Birthdate: _____

Have you ever had an Endoscopy? ☐Yes ☐No

If Yes, when? _____

What were findings? _____
(polyps, diverticulitis, ect.)

_____

Do you have a family history of Colon / Rectal / Gastrointestinal Cancer?

☐Yes ☐No

Do you have any of the following symptoms?

☐Pain / Vomiting
☐Bleeding
☐Weight Loss
☐Anemia
☐Diarrhea
☐Constipation
☐Fatigue
☐Change in Bowel Movements? (size, shape, color, floating, ect.)

☐ Incontinence
☐ Cirrhosis
☐ Hepatitis A/B/C
☐ Re-flux
☐ Ulcers
☐ Barrett's Esophagus
☐ Swallowing Trouble

Do you have any of the following

	Yes	No
Crohns or Ulcerative Colitis		
Irritable Bowel Syndrome		
Heart Issues (MI, arrhythmia, CHF, ect.)		
Pulmonary Issues (COPD, asthma, ect)		

	Yes	No
Stoke, Seizures, Fainting		
Kidney Failure / Dysfunction		
Diabetes		
Defibrillator, Pacemaker, Stents		
Sleep Apnea, Organ Transplant		
Heart or Chest Surgery		
Colon / Rectal Surgery		
Weight Loss Surgery		
Take blood thinners (Aspirin, Plavix, ect.)		
Use Tobacco (Smoking, Dip, Snuff)		
Recreational Drug Use (Marijuana, ect.)		
Problems with Bowel Preparation		

Drug Allergies ☐Yes ☐No

If yes, list: _____

_____

Current Height: _____

Current Weight: _____

Is there anything in your medical history that you wish to discuss with Dr. Kovacev which is not listed above?

_____

_____

_____

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