



COLUMBIA UNIVERSITY
MEDICAL CENTER

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Diagnostic Colonoscopy Questionnaire

Patient Name: _____ **Birth Date:** _____ **Age:** _____

Date of Exam: _____ **Referring Physician:** _____

Referring Physician Name

Address/Telephone: _____

Indication/Symptoms: _____

Allergies: _____ **Prior Colonoscopy?** Y N

If Yes, Date of last test: _____ **Findings:** _____

Are you taking Aspirin or Coumadin Medications? Y N **Specify:** _____

Personal or Family History of the following:

- | | | |
|---|---|-------------|
| <input type="checkbox"/> Colon or GI Cancer | <input type="checkbox"/> Personal <input type="checkbox"/> Family | Type: _____ |
| <input type="checkbox"/> Colonic Polyps | <input type="checkbox"/> Personal <input type="checkbox"/> Family | |
| <input type="checkbox"/> Hemorrhoids | | |
| <input type="checkbox"/> Constipation | Frequency: _____ | |
| <input type="checkbox"/> Rectal Bleeding | Frequency: _____ | |
| <input type="checkbox"/> Abdominal Pain | Frequency: _____ | |

Please list any other Medical Problems or Conditions:

