

LENOX HILL RADIOLOGY & MEDICAL IMAGING ASSOCIATES P.C.

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: / /