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Fast Track Colonoscopy

Please complete this packet and return to Dr. McEachern's office.
The scheduler will call to arrange a procedure date.

Legal Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Work Phone: _____

Insurance Company: _____ Effective Date: _____

Policy #: _____ Group #: _____

Best number and time to reach patient during the day: _____

Internal Office Use Only:

MRN#: _____ PCP: _____

Height: _____ Weight: _____ BMI: _____ Age: _____

Meds: _____

Allergies: _____

Anesthesia: _____ IV Start: _____ Pharm: _____

Fast Track Colonoscopy

Legal Name: _____ Date of Birth: _____

Patient's Social History:

Marital status: Married Single Separated Divorced Widow(er)

Are you currently: Pregnant or trying to conceive: Y N Breast feeding: Y N

Tobacco Use:

Cigarettes Not Used Active ___ Per Day ___ Years Used ___ Quit Date

Cigars Not Used Active ___ Per Day ___ Years Used ___ Quit Date

Smokeless Not Used Active ___ Per Day ___ Years Used ___ Quit Date

Illicit Drug Use:

Cocaine Not Used Active ___ Per Day ___ Years Used ___ Quit Date

IV Drugs Not Used Active ___ Per Day ___ Years Used ___ Quit Date

Marijuana Not Used Active ___ Per Day ___ Years Used ___ Quit Date

Meth Not Used Active ___ Per Day ___ Years Used ___ Quit Date

Other Not Used Active ___ Per Day ___ Years Used ___ Quit Date

Alcohol Use:

Beer Not Used Active ___ Per Day ___ Years Used ___ Quit Date

Wine Not Used Active ___ Per Day ___ Years Used ___ Quit Date

Mixed drinks Not Used Active ___ Per Day ___ Years Used ___ Quit Date

Hard liquor Not Used Active ___ Per Day ___ Years Used ___ Quit Date

Fast Track Colonoscopy

Legal Name: _____ Date of Birth: _____

Please circle any of the following blood relatives who have had:

Colon cancer:	Mother	Father	Sister	Brother
Colon polyps:	Mother	Father	Sister	Brother
Crohn's/ Ulcerative colitis:	Mother	Father	Sister	Brother
Esophageal cancer:	Mother	Father	Sister	Brother
Stomach cancer:	Mother	Father	Sister	Brother
Cancer:	Mother	Father	Sister	Brother
Diabetes:	Mother	Father	Sister	Brother
Heart disease:	Mother	Father	Sister	Brother
High blood pressure:	Mother	Father	Sister	Brother
High cholesterol:	Mother	Father	Sister	Brother
Hypertension:	Mother	Father	Sister	Brother
Melanoma:	Mother	Father	Sister	Brother
Obesity:	Mother	Father	Sister	Brother

Other Cancer: _____ Onset: _____

Please circle any of the following you have had in the past month:

Headache	Yellow eyes	Heartburn	Rectal pain
Fever	Mouth sores	Constipation	Frequent urination
Dizzy/Light headed	Difficulty swallowing	Diarrhea	Difficulty sleeping
Shortness of breath	Nausea/Vomiting	Blood in stools	Unexpected weight loss
Loss of memory	Chest pain	Black/Tarry stools	

Please list any other medical conditions current or past we should be aware of:

Prior colonoscopy / Flexible sigmoidoscopy: _____

Where: _____ When: _____

Fast Track Colonoscopy

Legal Name: _____ Date of Birth: _____

Patient's Medical History (*Past or Present*)

	Date		Date		Date
ADD/Hyperactive	_____	Depression	_____	Leukemia	_____
Alcoholism	_____	Diabetes I/II	_____	Liver disease	_____
Allergies	_____	Diabetes complication	_____	Lung disease	_____
Anemia	_____	Difficulty swallowing	_____	Melanoma	_____
Angina/Chest pain	_____	Diverticulosis	_____	Overweight	_____
Anxiety	_____	Emphysema	_____	Parkinson's	_____
Arthritis (osteo)	_____	Fatty liver	_____	Pedal edema	_____
Asthma	_____	Fibromyalgia	_____	Pneumonia	_____
Atrial fibrillations	_____	Gastritis	_____	Prostatism	_____
Bipolar	_____	GI Bleed	_____	Renal insufficiency	_____
Bladder problems	_____	Glaucoma	_____	Rheumatic fever	_____
Bleeding problems	_____	Head trauma	_____	Scarlet fever	_____
Blood clots	_____	Heartburn/GERD	_____	Schizophrenia	_____
Blood transfusion	_____	Hemorrhoids	_____	Seizures	_____
Bronchitis	_____	Hepatitis/Jaundice	_____	STDs	_____
Cirrhosis	_____	High blood pressure	_____	Sleep apnea	_____
Colon polyps	_____	High cholesterol	_____	C-PAP	_____
Cong. heart failure	_____	HIV/AIDS	_____	Stroke/Mini-stroke	_____
Constipation	_____	Hyperthyroidism	_____	Substance abuse	_____
COPD	_____	Hypothyroidism	_____	Thyroid disease	_____
Coronary artery dis.	_____	Irritable bowel	_____	TMJ	_____
Coumadin use	_____	Kidney disease	_____	Tuberculosis	_____
Crohn's disease	_____	Kidney stones	_____	Ulcerative colitis	_____

Cancer or Other: _____ Onset: _____

Patient's Surgical History

	Date		Date		Date
Adenoidectomy	_____	EGD	_____	Joint replacement	_____
Angioplasty	_____	Eye lid surgery	_____	Prostate surgery	_____
Appendectomy	_____	Gallbladder	_____	Pacemaker	_____
Breast biopsy L/R	_____	Heart valve replacement	_____	Septum repair	_____
Cardiac bypass	_____	Hemorrhoidectomy	_____	Sinus repair	_____
Cataracts L/R	_____	Hernia	_____	Thyroid surgery	_____
Cholecystectomy	_____	Hip replacement L/R	_____	Tonsillectomy	_____
Circumcision	_____	Hysterectomy	_____	Tympanostomy	_____
Cesarean section	_____	Vag or Abd/Ovaries	Y N	Tubal ligation	_____
Ear tubes	_____	Implant defibrillator	_____	Vasectomy	_____

Other: _____ Onset: _____