CONSENT FORM

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SCREENING COLONOSCOPY QUESTIONNAIRE

1. Patient's name

2. Date of Birth 3. Weight 4. Height (CM)

5. Do you have any history heart lung liver or kidney disease? (If yes please list) Yes No

6. Do You have a pace maker or implanted defribulator Yes No
7. Are you anaemic? Or suffer from anaemia? Yes No
8. Are you on any blood or high risk medications? Yes No
9. Have you been diagnosed with Inflammatory Bowel Disease (Colitis)? Yes No
10. Have you had any severe, frequent changes in your bowel habits in the last 30 days? Yes No
    (For example, diarrhea, constipation, or other) Yes No
11. Have you notice any bright red or brown blood in your stools? Yes No
12. Have you had any frequent cramping and or abdominal tenderness in the past? Yes No
13. Are you experiencing any rectal pain that will not subside Yes No
14. Have you had a drop in weight, without diet or increased exercise that would cause concern? Yes No
15. Do you feel any weakness or fatigue that is more than normal with bowel changes? Yes No
16. Are you over 50 years old and your GP referred you for a colonoscopy screening for bowel cancer? Yes No
17. Do you have any family history of any cancers? Yes No
    If yes, what kind When Who
18. Have you had any previous endoscopy? Yes No
    If yes, what kind? When Result
19. Have you had any surgical procedures? (if yes, what kind?) Yes No

20. Do you have any allergies (if yes please list) Yes No

21. Are you taking any medications (if so, please list) Yes No

Patient's Signature: Date: