Newton Medical Center

Fast Track Colonoscopy

Please Fill Out Completely

Provider

☐ John McConeghey, MD ☐ John McEachern, MD ☐ Jered Windorski, MD ☐ First Available

Personal Information

Last Name:	First Name:	Middle Name:
☐ Male ☐ Female	SSN:	Date of Birth (MM/DD/YYYY): / /
Address: Apt#:	City: State:	Zip:
Home Phone:	Cell Phone:	Work Phone:
Email Address:	Race/Ethnicity:	
Marital Status:	Primary Language:	Religion:
Employer Name:	Employment Status (Check all that apply)	
Employer Phone:		
Employer Address:	☐ Full-Time ☐ Part-time ☐Not Employed	
	☐ Student (Full-Time) ☐ Student (Part-Time)	
City: State: Zip:	☐ Active Military Duty ☐ Self-Employed	
	☐ Retired Retirement Date:_____	
Primary Care Physician:		

Health Insurance

Please enter information as it appears on your card

Primary Insurance		
Subscriber Name:	Patient's Relationship to Subscriber:	
☐ Male ☐ Female	SSN:	Date of Birth (MM/DD/YYYY): / /
Address: Apt#:	City: State:	Zip:
Home Phone:	Employment Status: ☐ FT ☐ PT ☐ Other:	
Employer Name:	Employer Phone:	
Employer Address:	City: State:	Zip:
Insurance Company Name:	Insurance Company Address:	
Policy #		
Group #	City: State:	Zip:
Secondary Insurance		
Subscriber Name:	Patient's Relationship to Subscriber:	
☐ Male ☐ Female	SSN:	Date of Birth (MM/DD/YYYY): / /
Address: Apt#:	City: State:	Zip:
Home Phone:	Employment Status: ☐ FT ☐ PT ☐ Other:	
Employer Name:	Employer Phone:	
Employer Address:	City: State:	Zip:
Insurance Company Name:	Insurance Company Address:	
Policy #		
Group #	City: State:	Zip:

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Legal Name:_____ Date of Birth:____/_____/_____

Patient's Medical History

Please Check All That Apply

- ☐ None
- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostatic Hypertrophy
- ☐ Blood Clots
- ☐ Cancer_____
- ☐ CVA/Stroke
- ☐ COPD
- ☐ CAD/Heart Disease
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Gall Bladder Disease
- ☐ GERD/Heartburn
- ☐ Hepatitis C
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Irritable Bowel
- ☐ Liver Disease
- ☐ Diabetes
- ☐ Migraine Headaches
- ☐ Myocardial Infarction
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic Ulcer Disease
- ☐ Renal Disease
- ☐ Seizure Disorder
- ☐ Thyroid Disease

Patient's Surgical History

Please Check All That Apply

- ☐ None
- ☐ Appendectomy
- ☐ Arthroscopy Knee
- ☐ Back Surgery
- ☐ CABG
- ☐ Carpal Tunnel
- ☐ Cataract
- ☐ Colon Resection
- ☐ DVT
- ☐ Other_____
- ☐ Gastric Bypass
- ☐ Heart Catheterization
- ☐ Hernia Repair: Type_____
- ☐ Knee Replacement
- ☐ Liver Biopsy
- ☐ Pacemaker
- ☐ Small Bowel Resect
- ☐ Thyroidectomy
- ☐ Tonsillectomy

Female

- ☐ Bilateral Tubal Ligation
- ☐ Breast Biopsy
- ☐ Cesarean Section
- ☐ Hysterectomy ☐ Total
- ☐ Mastectomy

Male

- ☐ Prostate Biopsy
- ☐ TURP
- ☐ Vasectomy

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Legal Name:_____ Date of Birth:____/_____/_____

Mark any of the following symptoms you have had in the past month

Please Check All That Apply

☐ Headache	☐ Yellow Eyes	☐ Heartburn/Acid Reflux	☐ Rectal Pain
☐ Fever	☐ Mouth Sores	☐ Constipation	☐ Dizzy-Light Headed
☐ Diarrhea	☐ Blood in Stool	☐ Difficulty Swallowing	☐ Loss of Memory
☐ Chest Pain	☐ Nausea/Vomiting	☐ Unexpected Weight Loss	☐ Shortness of Breath
☐ Chronic Cough	☐ Black/Tarry Stools		

Family History

Please Check All That Apply

	M F S B		M F S B
Alcoholism	☐ ☐ ☐ ☐	Asthma	☐ ☐ ☐ ☐
Blood Disease	☐ ☐ ☐ ☐	CAD/Heart Disease	☐ ☐ ☐ ☐
CVA/Stroke	☐ ☐ ☐ ☐	Cancer (type)_____	☐ ☐ ☐ ☐
Colon Cancer	☐ ☐ ☐ ☐	Crohn's Disease	☐ ☐ ☐ ☐
Diabetes	☐ ☐ ☐ ☐	Esophageal/Stomach Cancer	☐ ☐ ☐ ☐
Hypertension	☐ ☐ ☐ ☐	Irritable Bowel Disease	☐ ☐ ☐ ☐
Renal Disease	☐ ☐ ☐ ☐	Seizure Disorder	☐ ☐ ☐ ☐

Other_____

M=Mother F=Father S=Sister B=Brother

Patient's Medical History

Please Check All That Apply

Marital Status

☐ Married
☐ Single
☐ Divorced
☐ Widow/Widower

Women

☐ Pregnant/Trying to Conceive
☐ Breast Feeding
☐ N/A

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Tobacco Use

☐ Current ☐ Former ☐ Never

☐ Cigarette ☐ Cigar ☐ Chew

Units Per Day:_____

Years Used:_____

Years Quit:_____

Alcohol Consumption

☐ No

☐ Yes

Type:_____

Frequency_____

Years Quit:_____

Patient's Colonoscopy History

☐ Check here if you have no colonoscopy history

Flexible Sigmoidoscopy/Colonoscopy

Date:_____	Where:_____	Results:_____
Date: _____	Where:_____	Results:_____
Date:_____	Where:_____	Results:_____
Date:_____	Where:_____	Results:_____

Once completed, please return to Newton Surgical Group via:

- Email – nsg@newtonmed.com
- Fax – 316-283-2968
- Mail – PO Box 308, Newton Ks, 67114