DR. WEISBERG OPEN ACCESS SCREENING

Name:______________________________ DOB:______________

Symptoms:______________________________ Last Colon:______________________________

Do you have any heart conditions or rhythm abnormalities? Yes No
(CHF, Valve disorder, Heart attack)
Do you have a pacemaker or defibrillator? Yes No
Do you have any lung or breathing problems? Yes No
Do you have family history of colon cancer? Yes No
If yes, who?______________________________
Are you over the age of 50? Yes No
Are you diabetic? Yes No
Do you have any bleeding or circulatory disorders? Yes No
Are you on dialysis or have kidney problems? Yes No
Surgeries:______________________________
Do you have sleep apnea? Yes No
If yes, CPAP or Oxygen
Diagnosed with any type of cancer? Yes No
If yes, type:______________________________
Do you have a history of seizures? Yes No
Do you have a latex allergy? Yes No
Do you drink alcohol? Yes No
If yes, how much/how often?______________________________
Do you use recreational drugs? Yes No
If yes, what kind?______________________________
How often do you have a bowel movement?______________________________
Current Weight:______________________________ Height:______________________________
Do you have any drug allergies? Yes No
If yes, which meds?______________________________

Medication	Dose	Frequency	Medication	Dose	Frequency

Notes:______________________________

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Completed By:______________________________ Date:______________________________