GASTROINTESTINAL
ASSOCIATES, P.C.

IMPORTANT: Please read packet in full. Fill out all needed information and mail back paperwork so it arrives 48 hours prior to procedure. If you are not able to return your information by mail on time please visit https://gia.mygportal.com/PP6-1-10/Account/LogOn to complete online.

Dear_____,

Your colonoscopy with Dr._____ is scheduled for:

Date: _____

Arrival Time: _____ for _____ appointment.

Location: _____ 1311 Dowell Springs Blvd, Knoxville, TN 37909

_____ 629 Delozier Way, Powell, TN 37849, Suite 2

_____ 11440 Parkside Dr, Knoxville, TN 37934, First Floor, Suite 100

Please follow all dietary instructions in this packet and NOT the instructions provided in the prep box

If you are new to our practice or have not been seen in over one year, you must complete the enclosed forms and mail or bring them back to one of our offices as soon as possible so that we will receive no later than 48 hours prior to your starting your prep. ***If you are not able to return your information by mail on time please visit https://gia.mygportal.com/PP6-1-10/Account/LogOn to complete online.*** The information sheet is needed to verify your insurance information and obtain necessary referrals or pre-certification. This will also allow us to provide you with information on estimated out of pocket expenses prior to your colonoscopy. Please be sure to bring your insurance cards and driver's license to your appointment. We participate with a large number of insurance carriers but if you have a co-pay or have not met your deductible, you will need to be prepared to pay the unmet portion on the day of your procedure. The medical forms will give us your past and present medical history, as well as a list of your current medications and allergies.

- If you take aspirin (325 mg or less) or NSAIDs (Advil, Aleve, Motrin, Mobic or ibuprofen), you may continue to take them as usual.
- If you take blood thinner or high dose aspirin (greater than 325 mg), see attached sheet for instructions. Check with your doctor to be sure it is safe to hold your medication.
- Stop taking Iron supplements and multivitamins that contain either Iron or Vitamin E.
- **TYLENOL** products are okay to take prior to your colonoscopy.

PLEASE DO NOT STOP ANY BLOOD THINNERS UNTIL YOUR PRESCRIBING PHYSICIAN APPROVES THIS

This list is simply our recommendation and if your physician does not want you to stop your blood thinner, you will need to notify your physician's nurse at our office.

If you are diabetic, please contact your primary care or prescribing physician for recommendations on how to manage your diabetic medications prior to your colonoscopy. Usually patient do not take their diabetic medications on the day of the procedure but should bring the medication to the appointment if they choose to eat after the exam prior to returning home.

IF YOU HAVE AN IMPLANTED DEFIBRILLATOR WE CANNOT PERFORM YOUR COLONOSCOPY IN OUR SURGERY CENTER

Please notify your physician's nurse as soon as possible so that your procedure can be rescheduled in a hospital setting. If you have a pacemaker **ONLY** we can perform your colonoscopy as planned in our surgery center.

If you weight over 400 pounds or have a BMI of 50 or greater, call your physician's nurse at this office to see if we can safely perform your colonoscopy in an office setting.

Enclosed you will find the colonoscopy prep that your physician prefers. Please read all of the instructions carefully as soon as possible so that if you have questions, you will have time to call the office. Many of our colonoscopy preps require prescription laxatives. If your prep contains a prescription, please take it to your pharmacy several days before your appointment. **IT IS EXTREMELY IMPORTANT THAT YOU FOLLOW ALL INSTRUCTIONS EXACTLY AS THEY ARE WRITTEN** in order to obtain a satisfactory exam.

If you have questions regarding a medical condition or the preparation instructions, please call our office (865) 588-5121 and ask for your physician's nurse. You will need to leave a message and your call will be returned as soon as possible.

If you need to cancel or reschedule your appointment, please call (865) 588-5121 and ask for scheduling.

Thank you for allowing us to participate in your care.

Please reference the tables below when considering how long to stop your anti-coagulant and Injectable diabetic/weight loss medications before your procedure. Please also consult with your primary care doctor, your heart/lung specialist, or the prescribing physician for your anti-coagulant and diabetic medications for further clarification on the safety of stopping your medication (unless we've already done this for you). If your doctor denies you permission to stop your medication, please let your gastroenterologist know.

ANTI - COAGULANT MEDICATIONS	
Brilinta (ticagrelor)	Hold for 5 days prior
Coumadin (warfarin)	Hold for 5 days prior
Effient (prasugrel)	Hold for 7 days prior
Eliquis (apixaban)	Hold for 2-4 days (normal kidney function - 2 days)
Plavix (clopidogrel)	Hold for 5 days prior
Pradaxa (dabigatran)	Hold for 2-4 days (normal kidney function - 2 days)
Savaysa (edoxaban)	Hold for 1 day prior
Xarelto (rivaroxaban)	Hold for 2 days prior
Pletal (cilostazol)	Hold for 2 days prior
Aggrenox (aspirin & dipyridamole)	Hold for 7 days prior
Aspirin	Do not stop 81 or 325 mg. For 500 mg or more, **STOP** for 7 days

DIABETIC AND WEIGHT LOSS - INJECTABLE MEDICATIONS	
Byetta (exenatide)	Hold on day of procedure (twice daily injection)
Victoza (liraglutide)	Hold on day of procedure (once daily injection)
Tanzeum (albiglutide)	Hold for 1 week prior to procedure (once weekly injection)
Trulicity (dulaglutide)	Hold for 1 week prior to procedure (once weekly injection)
Lixumia (lixisenatide)	Hold on day of procedure (once daily injection)
Beinaglutide	Hold on day of procedure (three times daily injection)
Ozempic (semaglutide)	Hold for 1 week prior to procedure (once weekly injections)
Fu Laimel (peg-loxenatide)	Hold for 1 week prior to procedure (once weekly injection)
Mounjaro (tirzepatide)	Hold for 1 week prior to procedure (once weekly injection)
Wegovy (semaglutide)	Hold for 1 week prior to procedure (once weekly injection)
Bydureon (exenatide)	Hold on day of procedure (twice daily injection)
Rybelsus (semaglutide)	Hold for 1 week prior to procedure (once weekly injections)

GASTROINTESTINAL ASSOCIATES, P.C.
PATIENT INFORMATION RECORD

Date _____ **SS#** _____ **Age** _____

Name: Mr. / Mrs. / Miss / Ms. _____
Last First MI

Address: _____
Street Address (required) P.O. Box

_____
City State Zip County

Is the above address an Assisted Living Facility or Nursing Home? Yes ☐ No ☐

If yes, name of facility: _____

Telephone: **Home** _____ **Employer** _____
Work _____ **Employer Address** _____
Cell _____ _____

Text Appt. Reminders *Yes* ☐ *No* ☐

Preferred Method of Communication **Telephone** ☐ **Email** ☐ **Letter** ☐

Patient's Date of Birth _____

Patients's E-mail Address: _____

Emergency Contact Name: _____ **Phone #:** _____

Sex: **Male** **Female**

Marital Status: (check one) Married ☐ Single ☐ Widowed ☐ Divorced ☐ Legally Separated ☐ Other ☐

Spouse: **Name** _____ **DOB:** _____

Employer _____

Race: (check one) ☐ White / Caucasian ☐ Native Hawaiian / Other Pacific Islander ☐ American Indian or Alaskan Native
☐ Black / African American ☐ Asian ☐ More than one race ☐ Pt. refuses to report or unavailable

Ethnicity: ☐ Not Hispanic ☐ Hispanic or Latino ☐ Pt. declined or unavailable

Preferred Language _____

Referred by: **Doctor** _____ **Address** _____
Friend _____ **Newspaper** _____ **Other** _____ (specify)

Primary Care Physician _____

Insurance Information

Primary insured's name _____ **Date of birth** _____
Primary insured's insurance company _____
Primary insured's ID number _____ **Group #** _____
Secondary insured's name _____ **Date of birth** _____
Secondary insured's insurance company _____
Secondary isured's ID number _____ **Group #** _____
Do you have a Living Will or Advance Directives for Healthcare? _____
If yes, where is the document located? _____
Do you have a Durable Power of Attorney for Healthcare? _____
If yes, where is the document located? _____
Would you like information regarding a living will? _____

GASTROINTESTINAL
ASSOCIATES, P.C.

Address: 1311 Dowell Springs Blvd. Knoxville, TN 37909
Phone: 865-588-5121
Fax: 865-588-2126

Patient Interview Form

Patient Information

First Name: _____ Last Name: _____

Date Of Birth: _____ Age: _____

Notes: _____

Email
Please check one as your preferred email for communications

☐ Personal: _____ ☐ Work: _____

Race
Select one or more

☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Other Race ☐ Unknown ☐ Patient declines to specify ☐ Prohibited by state law

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify ☐ Prohibited by state law ☐ Unknown

Sex

☐ Male ☐ Female ☐ Other ☐ Unknown

Preferred Language

☐ English ☐ Spanish; Castilian ☐ Patient declines to specify

Contact Preference

☐ No Preference ☐ Email ☐ Letter ☐ Patient declines to specify Other: _____

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies

☐ Penicillins ☐ Sulfa ☐ Iodine Compounds ☐ Latex ☐ morphine (PF)

☐ Codeine Sulfate Other: _____

Current Medications

☐ None

Name	Dose	How taken?

Pharmacy

Name Address Phone

Immunizations

- ◯ None
- ◯ Flu vaccine When:
- ◯ Hep A When:
- ◯ Hep B When:
- ◯ Pneumovax When:
- ◯ TB skin test When:
- ◯ COVID-19 When:

Past or Present Medical Conditions

- ◯ None
- ◯ Anemia
- ◯ Anxiety
- ◯ Alzheimer's Dementia
- ◯ Asthma
- ◯ Arthritis (non-Rheumatoid)
- ◯ Atrial Fibrillation
- ◯ Barrett's Esophagus
- ◯ Bipolar Disorder
- ◯ Blood Clot - Leg (DVT)
- ◯ CANCER
- ◯ Cirrhosis
- ◯ Colon Cancer
- ◯ Colon Polyps
- ◯ Congestive Heart Failure
- ◯ COPD
- ◯ Coronary Artery Disease
- ◯ Crohn's Disease
- ◯ Dementia, type unspecified
- ◯ Depression
- ◯ Diabetes Mellitus
- ◯ Diverticulosis
- ◯ Fibromyalgia
- ◯ GERD / Reflux
- ◯ Glaucoma
- ◯ Gout
- ◯ Hepatitis C
- ◯ MI (Heart Attack)
- ◯ Hypertension
- ◯ Hyperlipidemia
- ◯ HIV
- ◯ Hypothyroidism
- ◯ IBS
- ◯ Kidney Failure
- ◯ Kidney Stones
- ◯ Lupus (SLE)
- ◯ Migraine Headaches
- ◯ Osteoporosis
- ◯ Parkinson's
- ◯ Psoriasis
- ◯ Pulmonary Embolism
- ◯ Rheumatoid Arthritis
- ◯ Scleroderma
- ◯ Seizure disorder
- ◯ Obstructive Sleep Apnea
- ◯ Peptic Ulcer Disease
- ◯ Stroke (CVA)
- ◯ TIA
- ◯ Ulcerative Colitis

Other: Other: Other:

Previous Procedures

- ◯ None
- ◯ Abdominal Hernia Repair
- ◯ Anal Fissure Repair
- ◯ Aneurysm Repair
- ◯ Appendectomy
- ◯ Back Surgery
- ◯ Bladder Lift/Tack
- ◯ Breast Augmenation
- ◯ Breast Reduction
- ◯ Cardiac Cath
- ◯ Cardiac Stent
- ◯ Carotid Surgery/Stent
- ◯ Cataract Removal
- ◯ C-Section
- ◯ Colectomy - partial
- ◯ Colectomy - total
- ◯ Colostomy Bag
- ◯ Coronary Bypass (CABG)
- ◯ D and C
- ◯ Defibrillator Placement
- ◯ Exploratory Laparotomy
- ◯ Gastrectomy - Partial
- ◯ Gastric Bypass Surgery
- ◯ Gallbladder Removal
- ◯ Hemorrhoid Surgery
- ◯ Hiatal Hernia repaired
- ◯ Hip Replacement
- ◯ Hysterectomy
- ◯ Knee Surgery
- ◯ Gastric Lap Band
- ◯ Laparoscopy
- ◯ Mastectomy
- ◯ Ovary Removal
- ◯ Pacemaker Insertion
- ◯ Prostate Removal
- ◯ Sinus Surgery

☐ Splenectomy ☐ Thyroidectomy ☐ Tonsillectomy ☐ Tubal (BTL) ☐ Valve (Heart) Replacement

Other: Other: Other: Other: Other:

Diagnostic Studies/Tests

☐ None

☐ Colonoscopy ☐ Endoscopy ☐ Ultrasound ☐ HIDA scan ☐ CT Scan

When: When: When: When: When:

Family Medical History

☐ No knowledge of family history

No family history of

☐ Celiac Disease
☐ Colon polyps
☐ Gastric Cancer
☐ Liver disease
☐ Pancreatitis
☐ Ulcerative colitis
☐ Colon cancer
☐ Crohn's disease
☐ GI Cancers
☐ Pancreatic Cancer
☐ Stomach Cancer

Diagnoses	Mother	Father	Sister	Brother	Grandmother	Grandfather
Celiac Disease	○	○	○	○	○	○
Crohn's / Regional Enteritis	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○
Gastric Cancer	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Social History

Occupation: Number of Children:

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Alcohol

☐ None

Type	Quantity	Number	Frequency

Tobacco

Smoking Status

- ◯ Current every day smoker
- ◯ Current some day smoker
- ◯ Former smoker
- ◯ Never smoker
- ◯ Smoker, current status unknown
- ◯ Light tobacco smoker
- ◯ Heavy tobacco smoker
- ◯ Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

◯ Yes ◯ No

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

◯ Yes ◯ No

Review Of Systems

Cardiovascular

◯ None

	Y	N
chest pain	◯	◯
irregular heart beat	◯	◯
passing out/fainting	◯	◯

Constitutional

◯ None

	Y	N
fatigue	◯	◯
weight loss	◯	◯
fever/chills	◯	◯

Integumentary

◯ None

	Y	N
hives	◯	◯
itching	◯	◯
rash	◯	◯

ENMT

◯ None

	Y	N
sore throat	◯	◯
mouth sores	◯	◯
hoarseness	◯	◯

Gastrointestinal

◯ None

	Y	N
abdominal pain	◯	◯
change in bowel habits	◯	◯
constipation	◯	◯
diarrhea	◯	◯
trouble swallowing	◯	◯
blood in stool	◯	◯

Genitourinary

◯ None

	Y	N
blood in urine	◯	◯
urinary incontinence	◯	◯
prostate trouble	◯	◯

Endocrine

◯ None

	Y	N
excessive thirst	◯	◯
hair loss	◯	◯
heat intolerance	◯	◯

Musculoskeletal

◯ None

	Y	N
arthritis	◯	◯
back pain	◯	◯
muscle weakness	◯	◯

Neurological

◯ None

	Y	N
dizziness	◯	◯
frequent headaches	◯	◯
seizures	◯	◯

Hematologic/Lymphatic

◯ None

	Y	N
easy bruising	◯	◯
enlarged lymph nodes	◯	◯
prolonged bleeding	◯	◯

Psychiatric

◯ None

	Y	N
anxiety	◯	◯
depression	◯	◯
panic attacks	◯	◯

Reminder Preference

I would like to receive preventive care and follow up care reminders.

Yes No

Reviewed with

Patient Parent Guardian Not Present

Signature

Signature Date