MWHC Health Scan™ Medical Imaging of Fredericksburg

VIRTUAL COLONOSCOPY
PATIENT MEDICAL INFORMATION FORM

Patient Name: _____

D.O.B. _____/_____/_____

Home Address_____

_____ _____

Best Contact Telephone: ( )_____ Alternative Telephone: ( ) _____

Referring Physician: ___ _____Primary Care Physician_____

Primary reason for having scan:

Risk Factors:

Family member with Colon Cancer	Yes___ No___
Genetic tagging showing increased risks	Yes___ No___
Prior Gastric Surgery or Resection	Yes___ No___
Prior Colon Cancer	Yes___ No___
History of Smoking	Yes___ No___

Medical History:

1.Do you have any allergies? If yes, please specify. _____

_____

2. Please list any previous surgery. _____

_____

Revised per Dr. Stacy Moulton 10/23/2020

Health Scan™
MWHC Medical Imaging of Fredericksburg

3. Any family history of cancer? If yes, please list type and relationship.

_____

You should understand this exam is not a substitute for a physical examination by your physician. It is not a substitute for a colonoscopy. It is an imaging aide to help detect abnormalities within the colon. Depending upon the results of your scan, other imaging tests or procedures may be recommended to you by your primary care doctor.

Please list any questions or concerns you may have in the space below, so we may answer them during the consultation:

Signature: _____ Date: _____