Surgeons of Northern Illinois
20 Tower Court, Suite A
Gurnee IL 60031
847-244-3525

Thank you very much for contacting our office and scheduling an appointment. Enclosed please find your paperwork, which needs to be completed prior to your scheduled appointment time.
Please complete the enclosed paperwork and bring with you to your scheduled appointment.

Your appointment is scheduled for: _____

20 Tower Court, Ste A
Gurnee IL 60031

If you have any further questions, please feel free to contact me at your convenience.

Sincerely,

Kayle

Surgeons of Northern Illinois

Initial Appointment Questionnaire

Thank you for choosing Surgeons of Northern Illinois. If you are considering weight loss surgery, please complete this packet in its entirety. You may return it to our office by mail or in person.

STEPS IN THE PROCESS:

1. Attend one of the Vista Weight Loss Surgery free public information seminars. A schedule of upcoming seminars can be found at http://www.vistahealth.com/vista-health-system/bariatricservices.aspx or by calling (847) 356-4745.

2. Complete and return this patient profile packet, in person or by mail. If you want, you may bring it with you to give to us at one of our seminars. Be sure to include a copy, front and back, of you insurance card. Our mailing address is:

   Surgeons of Northern Illinois
   20 Tower Court, Suite A
   Gurnee, IL 60031

   - Most insurance carriers require a letter of support from your Primary Care Provider (PCP). It is best to make this request early on, so that your PCP has time to discuss it with you and write an appropriate letter.
   - Most insurance carriers also require documentation of past weight loss attempts. There will be a place for you to list these attempts in this packet, but you should also submit supporting copies of any office visits, attendance or enrollment cards, weight charts, etc.

3. We will call and confirm the details of your insurance coverage for weight loss surgery. You may wish to do this on your own before submitting the packet, especially if you are unsure of your level of coverage. If your insurance unfortunately does not provide a bariatric surgery benefit, we will contact you to inform you, and give you information about Vista medical weight loss programs.

4. We will contact you to schedule an office consultation with the surgeon. Note that this does not commit you to anything, but rather a chance for you to explore on a personal level whether bariatric surgery is right for you in your unique situation. If you did not already submit the letter of support from your PCP or other supporting documentation, you should bring these with you to this visit.

PROCEDURES OFFERED:

1. Laparoscopic Gastric Bypass (Roux-en-y Bypass)

2. Laparoscopic/robotic Sleeve Gastrectomy

3. Laparoscopic/robotic Adjustable Gastric Banding

4. Laparoscopic/robotic Revisional Weight Loss Surgery

Thank you for your patience in this process. We understand it can be an arduous process but if you devote the time and energy it will be well worth your investment.

Michael F. Scheer, M.D., F.A.C.S. Daniel A. Liesen, M.D., F.A.C.S. Amit Parikh, D.O., F.A.C.O.S.

Thank you for selecting our healthcare Team! We will strive to provide you with the best possible care.
To help us meet all your healthcare needs, please fill out this form completely.
Your Driver's License and Social Security number is required in order to determine identity. It is the policy of our practice to implement an Identity Theft Prevention Program to detect, prevent and mitigate identity theft in connection with new and existing patient accounts.

Drivers License # _____

Patient Information *(CONFIDENTIAL)*

Soc. Security # _____

Last Name _____ *First Name* _____ *MI* _____
Address _____ *City* _____ *State* _____ *Zip Code* _____
Date of Birth _____ *Sex* _____ ***Phone#*** _____ *Marital Status* _____
Race: _____ *Language Preference:* _____
Pharmacy Preference and Location: _____
Occupation _____ ***Cell Phone #*** _____ *Email:* _____
Patient's Employer _____ *Work #* _____
Work Address _____ *City, State, Zip* _____
Spouse or Parent's Name _____ *Employer* _____ *Work #* _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency:
_____ *Phone #* _____ *Relationship:* _____

Name of Family Physician _____

Insured Information

Relationship to
Name of insured _____ *Patient* _____
Address _____ *Phone#* _____
City _____ *State* _____ *Zip Code* _____
Birthdate _____ *Soc. Sec. #* _____ *Work #* _____
Employer _____

Primary Insurance

HMO ____ *PPO* _____ *POS* _____ *Workman's Comp* ____ ***Co-pay amt.$*** _____
Insurance Company _____ *Group #* _____
Policy / I.D. # _____ *Phone #* _____
Address _____ *City* _____ *State* _____ *Zip* _____
If Workers Compensation: *Date of Injury* _____ *Contact Person:* _____
Phone # _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO If yes, complete the following
Name of Insured _____ *Relationship to Patient* _____
Birthdate _____ *Soc. Sec. #* _____ *Employer* _____
Insurance Company _____ *Group #* _____
Policy / I.D. # _____ *Phone #* _____
Address _____ *City* _____ *State* _____ *Zip* _____

Financial Arrangements: *For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment is expected at the time of service unless other arrangements have been made with our office.*
_____ ***Cash*** _____ ***Personal Check*** _____ ***Visa*** _____ ***MasterCard***

Authorization and Release

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize you to release and to receive any medical information to those you deem necessary. I hereby authorize my insurance company to pay directly to Surgeons of Northern Illinois benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____/_____
Signature of patient or parent if minor Date

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(847) 244-3525

FINANCIAL POLICY

The following is our financial policies, which we require you to read and sign prior to any treatment. As a courtesy to you, we will bill your insurance company if we are given necessary forms and information at the time of your initial service. All patients must complete our Patient Registration Form in full prior to being seen by any provider at Scheer and Liesen Surgical Associates.

All patient/guarantors are responsible for payment at the time of service of all co-payments, deductibles or co-insurance unless prior arrangements have been made.

We accept Cash, Check, MasterCard, Visa and Discover. You will be charged a $35.00 bank fee for any returned checks for any reason.

Insurance Co-payments

Insurance co-payments are paid at the time of service.

Deductible/Co-Insurance

If your insurance deductible is not met, full payment will be collected at the time of service. If your insurance deductible is met, your co-insurance amount will be collected at the time of service. Your insurance is a contract between you (the Subscriber), your employer and the insurance company. We are not a party to that contract. Should your insurance fail to pay, for any reason, you are responsible for the balance. We will transfer liability of the claim to you if your insurance does not properly pay within 45 days. Scheer and Liesen Surgical Associates expects you to be interactive and responsible for communicating with your insurance carrier on any open claims

Private Pay

If you have no insurance coverage or have insurance that we do not participate with, full payment is expected at the time of service unless prior arrangements have been made with our office.

Bariatric Procedures

We will contact your insurance company regarding eligibility and benefits and notify you with an estimated out of pocket cost that will be your responsibility. A $250.00 deposit is required prior to surgery which will be applied towards your account.

Collections

Once an account is placed in collections status, all future services must be paid in full at the time of service. Any balance assigned to our collection agency will be assessed a 40% fee, to offset the recovery expense.

I have read and agree to abide by this financial policy.

_____

(Signature) ***(Date)***

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.*
- *Obtain payment from third-party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician certifications.*

I have received, read and understand your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that Surgeons of Northern Illinois has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this office at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices.***

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I, _____, hereby request Surgeons of Northern Illinois to keep communication regarding my Protected Health Information confidential. To accomplish this request, please adhere to the following requests:

Communication Preference(s): ___Letter ___Cell ___Home ___Work

Phone: You can contact me by phone at _____ or _____
Leave messages on answering machine: ☐ Yes ☐ No

Can we send you e-mail reminders on appointments or account balances? ___Yes ___No
E-mail: You can contact me via e-mail @ _____

You may discuss my Protected Health Information with the following individuals:
Name _____Relationship_____ Phone #_____
Name _____Relationship_____ Phone #_____
Name _____Relationship_____ Phone #_____

Other requests for Confidential Communications: _____

Patient Signature: _____ Date: _____
If you are not the patient, please specify your relationship to the patient: _____

Surgeons of Northern Illinois

Welcome to our practice. As a new patient, or existing patient presenting with a new problem, please fill out the information found below to the best of your ability.

DATE: _____

PATIENT NAME: _____ **DATE OF BIRTH: _____Age: _____**

Referring or Primary care physician:_____

Obesity History:

How long have you been obese?_____
Highest adult weight (lbs.)_____
Lowest adult weight (lbs.)_____
How does your weight limit you?_____

Weight Management History	**Length of Time (Months)**	**Year**	**Weight Lost (lbs)**	**Weight Re-gained (lbs)**
Example: Low calorie diet	***10 months***	***2002***	***30 lbs.***	***20 lbs.***
Low calorie diet				
Low fat diet				
Atkins diet				
Optifast®/Medifast®				
Phen-fen				
Other prescription meds (Name: _____)				
Diet shots (B12, etc.) (Name: _____)				
Non-prescription diet pills (Name: _____)				
Doctor-supervised diet				
Registered Dietician (RD)				
Exercise program				
Nutrisystem®				
Weight Watcher®				
Jenny Craig®				
Other:				
Other:				
Other:				
Other:				

HEALTH HISTORY

Surgeons of Northern Illinois

DATE: _____
PATIENT NAME: _____ **DATE OF BIRTH:** _____**Age:** _____

Office Use Only
Temp _____ BP _____ / _____ Pulse _____ Height _____ Weight _____ Taken by: _____

Past Medical History: Have you ever had the following: (Please √ all that apply)

Acid Reflux ☐	Blood Clots ☐	Heart Disease ☐	Migraine Headaches ☐
AIDS or HIV + ☐	Bronchitis/COPD ☐	Hemorrhoids ☐	Mitral Valve Prolapse ☐
Anemia ☐	Cancer ☐	Hernia ☐	Pneumonia ☐
Arthritis ☐	Chickenpox ☐	Hepatitis ☐	Rheumatic Fever ☐
Asthma ☐	Depression ☐	High Blood Pressure ☐	Sleep Apnea ☐
Bladder Infection ☐	Diabetes ☐	High Cholesterol ☐	Thyroid Disease ☐
Back Trouble ☐	Epilepsy/Seizures ☐	Hives or Eczema ☐	Tuberculosis ☐
Bleeding Tendency ☐	Glaucoma ☐	Kidney Disease ☐	Venereal Disease ☐

Are you on any blood thinners?: Yes ☐ No ☐ (If yes, please list)_____
Can you walk up a flight of stairs without stopping? Yes ☐ NO ☐

Prior Surgeries/Hospitalizations/Diseases	**When?**	**Hospital, City. State**
None ☐		
Appendix (appendectomy) ☐	_____	_____
Gallbladder (cholecystectomy) ☐	_____	_____
Uterus (hysterectomy) ☐	_____	_____
Bariatric surgery ☐	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: None ☐

	Please list dosage and frequency	Please list over-the-counter medications, Vitamins, Herbal supplements, etc.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ANY KNOWN DRUG ALLERGIES: None ☐

_____ **Reaction:** _____
_____ **Reaction:** _____
_____ **Reaction:** _____

Patient Social History:

Occupation: _____
Marital status: Single: ☐ Married: ☐ Separated: ☐ Divorced: ☐ Widowed: ☐
Use of alcohol: Never: ☐ Rarely: ☐ Moderate: ☐ Daily: ☐
Use of tobacco: Never: ☐ Previously, but quit: ☐ Current packs / day:_____, Approximate duration_____
Do you use street drugs? ☐ Yes ☐ No

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father	___	_____	_____
Mother	___	_____	_____
Siblings	___	_____	_____
	___	_____	_____
Children	___	_____	_____
	___	_____	_____
	___	_____	_____

HEALTH HISTORY

Review of Systems: Please indicate any personal history below:

CONSTITUTIONAL SYMPTOMS
- Good general health lately ☐
- Recent weight gain ☐
- Recent weight loss ☐
- Fatigue ☐
- Fever ☐

EYES
- Eye disease or injury ☐
- Wear glasses/contact lenses ☐
- Blurred or double vision ☐

EARS/NOSE/MOUTH/THROAT
- Mouth sores ☐
- Bleeding gums ☐
- Hearing loss or ringing ☐
- Chronic sinus problem ☐
- Nose bleeds ☐
- Sore throat or voice change ☐
- Swollen glands in neck ☐

CARDIOVASCULAR
- Abnormal EKG ☐
- Heart trouble ☐
- Chest pain angina pectoris ☐
- Palpitation ☐
- Shortness of breath w/ walking or lying flat ☐
- Swelling of feet, ankles or hands ☐
- Heart murmur ☐

RESPIRATORY
- Chronic or frequent coughs ☐
- Spitting up blood ☐
- Shortness of breath ☐
- Wheezing ☐
- Tuberculosis ☐
- Asthma ☐
- Emphysema ☐

GASTROINTESTINAL
- Loss of appetite ☐
- Change in bowel movement ☐
- Nausea or vomiting ☐
- Frequent diarrhea ☐
- Painful bowel movements ☐
- Gallbladder problems ☐
- Rectal bleeding ☐
- Blood in stool ☐
- Hemorrhoids ☐
- Abdominal pain ☐
- Gastric Reflux ☐

GENITOURINARY
- Frequent urination ☐
- Burning or painful urination ☐
- Blood in urine ☐
- Change in force of stream when urinating ☐
- Incontinence or dribbling ☐
- Kidney stones ☐
- Sexual difficulty ☐
- Male – testicle pain ☐
- Female – pain with periods ☐
- Female – irregular periods ☐
- Female – vaginal discharge ☐
- Female - # of pregnancies _____
- Female - # of miscarriages _____
- Female – date of last pap smear _____
- Date of last menstrual period _____

MUSCULOSKELETAL
- Joint pain or stiffness ☐
- Difficulty in walking ☐
- Muscle weakness ☐
- Muscle pain or cramps ☐
- Back pain ☐
- Cold extremities ☐

INTEGUMENTARY (skin)
- Rash or itching ☐
- Change in skin color ☐
- Change in hair or nails ☐
- Varicose veins ☐

BREAST
- Breast pain ☐
- Breast lump ☐
- Nipple discharge ☐
- Date of last mammogram _____
- Date of Breast Biopsy _____
- Breast Rash ☐

NEUROLOGICAL
- Head injury ☐
- Light headed or dizzy ☐
- Convulsions or seizures ☐
- Numbness or tingling sensations ☐
- Stroke or mini-stroke ☐
- Tremors ☐
- Paralysis ☐
- Headaches ☐

PSYCHIATRIC
- Memory loss or confusion ☐
- Nervousness ☐
- Depression ☐
- Insomnia ☐
- Suicidal thoughts ☐
- Violent or Unusual thoughts ☐

ENDOCRINE
- Glandular or hormone prob ☐
- Excessive thirst or urination ☐
- Heat or cold intolerance ☐
- Skin becoming drier ☐
- Thyroid problems or goiter ☐

HEMATOLOGIC/LYMPHATIC
- Enlarged glands ☐
- Slow to heal after cuts ☐
- Bleeding or bruising tendency ☐
- Anemia ☐
- Phlebitis/Blood clots ☐

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:
- Penicillin ☐
- Other Antibiotics _____ ☐
- Novocain ☐
- Other Anesthetics _____ ☐
- Aspirin ☐
- Other pain remedies _____ ☐
- Iodine ☐
- Morphine ☐
- Demerol ☐
- Other narcotics _____ ☐

Known food Allergies: _____

_____

Anesthesia problems: _____

_____

Environmental allergies: _____

_____

LATEX ALLERGY ☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Signature of Patient or Guardian_____ Date: _____

Signature of Doctor_____ Date: _____

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SCREENING FOR SLEEP APNEA

Please check the box in front of the correct response,

Do you have sleep apnea? ☐ Yes ☐ No
If yes, what type of breathing equipment do you use at night to help you sleep _____.

If *yes* then you are done with this survey, otherwise, continue below:

1. Snoring:
   a) Do you snore on most nights (more than 3 times/week)? ☐ Yes (2) ☐ No (0)
   b) Is your snoring loud (can it be heard through a door or wall)? ☐ Yes (2) ☐ No (0)
2. Has it ever been reported to you that you stop breathing or gasp during sleep?

   ☐ Never (0) ☐ Occasionally (3) ☐ Frequently (5)

3. What is your collar size? Male: ☐ less than 17 inches (0) ☐ 17 inches or greater (5)

   Female: ☐ less than 16 inches (0) ☐ 16 inches or greater (5)

4. Have you had, or are you currently being treated for high blood pressure? ☐ Yes (2) ☐ No (0)
5. Do you occasionally doze or fall asleep during the day when:
   a) You are not busy or active? ☐ Yes (2) ☐ No (0)
   b) You are driving or stopped at a light? ☐ Yes (2) ☐ No (0)

Score:
9 points or more: Order a sleep study or refer to sleep specialist
6-8 Points: Gray area-use clinical judgment
5 Points or less: Low probability of sleep apnea

Patient Name: _____
D.O.B.: _____
Score: _____

Your Psychological Evaluation - FAQ's

*Compiled by Dr. Robbie Maller Hartman, Clinical Psychologist

- **What is a bariatric psychological evaluation?**

A bariatric psychological evaluation is an individual appointment with a licensed clinical psychologist to make sure you are ready psychologically for weight loss surgery. The purpose of the evaluation is to:

1. Identify your psychosocial strengths & potential challenges to surgery
2. Evaluate your understanding of risks & benefits of bariatric surgery
3. Make sure you have realistic goals & outcome expectations
4. Assess for ability to make the necessary lifestyle change
5. Assess your understanding of the behavioral changes necessary after surgery
6. Obtain social, educational & work history, psychiatric history, diet & weight history
7. Identify known co-morbid medical problems

- **Why do I need a psychological evaluation?**

Your surgeon and your health insurance carrier both require the psychological evaluation before they will approve your surgery.

- **When should I have the psychological evaluation?**

It depends. Once the evaluation is completed, it is only valid for 6 months. If your scheduled surgery is more than 6 months from the date of the evaluation, you will not be able to have the surgery without having a second evaluation which your insurance may or may not pay for.
If you have insurance that requires 6 month non-surgical weight management with your primary care doctor, you will need to wait until you have been in the program for 3 or more months. You also must have seen the dietician and exercise physiologist before your psychological evaluation.

- **How do I schedule the psychological evaluation?**

You may schedule your appointment directly with the psychologist, Dr. Robbie Maller-Hartman, by calling 847-984-6544. The psychologist is only in the office 2 ½ days per week, so do not be concerned if it takes several days before your call is returned. Best days to call are when Dr. Robbie is in the office. She is at the Lindenhurst Surgery Center on Tuesdays and at Vista Imaging Vernon Hills on Wednesday afternoons and Thursday mornings.

- **How do I prepare for my psychological evaluation?**

The best way to prepare is to study the bariatric manual. You need to know about your surgery (how it's done) and what the risks are. You also need to know details about the bariatric diet. Try to get a good night's sleep and eat a healthy breakfast before your appointment. Relax, and answer the questions honestly.

- **How do I pay for the evaluation?**

You should check with your insurance company to find out if bariatric psychological evaluation is covered. Medicaid and Medicare usually cover 100% of the evaluation so there is no copay. Some private insurance companies require an out of pocket copay or coinsurance payment, so be sure to bring payment for this with you to the appointment if you know you have a copay.

- **What else do I need to bring with me?**

You should bring a referral from your surgeon, a photo ID, and your health insurance card(s). Also be sure you have the correct appointment time and date, the address, and if necessary, directions. Also, there is a written part, so if you wear glasses for reading, you will need to bring them.

- **Can I bring someone with me?**

While you may drive with a friend or relative, you may not bring anyone into the interview with the psychologist or have anyone help you fill out the written part of the evaluation. This is to protect your privacy. You may not bring unsupervised infants or children to the waiting room with you unless you also bring a caregiver. Office staff cannot be responsible for childcare and infants and children will not be allowed into the evaluation.

- **What happens during the evaluation?**

You will have a one to one interview with the psychologist in which you will discuss your life history, physical and mental health history, weight and eating history, and things you should know about the surgery, such as risks and the bariatric diet. You will complete a brief true-false personality questionnaire. Additional tests or consultation with your therapist (if you have one) may be done on a case by case, as needed basis. The entire process should take less than 2 hours on average.

- **How long does it take for my doctor to get the results?**

The written personality questionnaire takes to score and get the computerized report. A written report will be sent you your surgeon about 2 weeks after your appointment. You should not schedule a follow-up with your surgeon prior to this unless told to do so.

EGD

What is EGD?

Esophagogastroduodenoscopy, or EGD, is an endoscopic examination of the esophagus, stomach and duodenum (the uppermost part of the small intestine) for hiatal hernias, ulcers, bleeding sources, tumors or other problems. The procedure can also offer a number of therapeutic interventions such as control of bleeding, manometry, or dilation. The procedure's medical name is actually a combination of the names of three different procedures that are usually performed collectively:

- **Esophagoscopy**—looking inside the esophagus for hiatal hernias, polyps, strictures, etc.
- **Gastroscopy**—looking inside the stomach for ulcers, polyps, inflammation, etc.
- **Duodenoscopy**—looking inside the duodenum for inflammation, diverticulosis, etc.

Together, the three procedures are referred to as EGD, or Upper Endoscopy. The EGD procedure is usually done by a GI doctor (Gastroenterologist). Your GI doctor might order an EGD if you are displaying persistent dysphagia (difficulty swallowing), if you bleeding either when you cough or pass stool, if you have GERD (acid reflux disease) or if you've had unexplained abdominal or chest pains. If you're vomiting severely, the procedure may also be able to find an underlying cause.

What Happens During an EGD Procedure?

After the patient is adequately sedated, a flexible device called an endoscope is inserted into a patient's throat and guided downward through the gastrointestinal tract, all the way to the duodenum. There is a little fiber-optic light and a camera attached to the endoscope's tip, which gives the GI doctor a view of the inner lining of the GI tract while the endoscope passes through. The procedure is very similar to a traditional colonoscopy, except that it is performed to the upper GI tract and not the lower intestines.

The entire process takes no more than 20 minutes. It is slightly uncomfortable when the endoscope is initially inserted, with the sedation, you will hardly feel it. Before the doctor examines you, he or she might pump air into your throat using the tubular endoscope to inflate the muscles and open the tract for a better view. Getting air pumped through your body can sometimes cause cramps or slight pain in the chest

How Do I Prepare for an EGD?

Your upper GI tract—the esophagus, stomach and duodenum—must be empty if you want the EGD to produce accurate results. Food remaining in the tract can get in the way of the doctor's examination and can look like something suspicious. To empty your upper GI tract, simply stop eating food and drinking beverages for 8 to 12 hours before the EGD. Also note that you will not be able to eat or drink anything for a couple of hours after the EDG, as well, because if you eat while sedated you might choke without feeling or noticing it.

In general, the preparation required before and after screenings of the upper GI tract is much preferred to bowel prep required for a colonoscopy or other lower GI exam, for which you'll need to consume laxatives and use the bathroom frequently to empty the colon completely. If you have questions about bowel prep, EGD or colonoscopy—you can always contact a medical doctor listed in our directory and schedule an appointment, or fill out one of the questions forms around the site for more information.