MEDICAL HISTORY

First Name Middle Int. Last Name Month Day Year Birthdate Sex

Describe the symptoms that led to your appointment: _____

When did the symptoms begin? _____

Your Past Medical History: Have you had any of the following?

GASTROINTESTINAL	No	Yes
Barrett's esophagus	( )	( )
Ulcers, stomach or duodenum	( )	( )
Colon or Rectal polyps	( )	( )
Crohn's disease	( )	( )
Diverticulitis	( )	( )
Diverticulosis	( )	( )
Irritable bowel syndrome	( )	( )
Ischemic colitis	( )	( )
Ulcerative colitis	( )	( )
Have you ever had blood found in a stool test?	( )	( )
Cirrhosis	( )	( )
Hemochromatosis	( )	( )
Liver disease, Jaundice	( )	( )
Viral hepatitis	( )	( )

CARDIOVASCULAR	No	Yes
Anemia	( )	( )
Atrial Fibrillation	( )	( )
Heart attack	( )	( )
High triglycerides/cholesterol	( )	( )
Heart valve replaced (If yes, date of surgery) _____		
Pacemaker/Defibrillator (If yes, date of surgery) _____		
High blood pressure	( )	( )
Congestive heart failure	( )	( )

RESPIRATORY	No	Yes
Asthma	( )	( )
COPD	( )	( )
Sleep apnea	( )	( )

CANCER	No	Yes
Stomach	( )	( )
Colon / Rectal	( )	( )
Breast	( )	( )
Ovarian	( )	( )
Uterine	( )	( )
Other (Type)	( )	( )

GENERAL	No	Yes
Arthritis	( )	( )
Depression	( )	( )
Diabetes	( )	( )
Kidney disease	( )	( )
Seizure, Epilepsy	( )	( )
Stroke	( )	( )
Thyroid disorder	( )	( )
Vascular graft	( )	( )

SURGERIES	No	Yes	If yes, when?	Where was it performed?
Have you had gallstones removed?	( )	( )		
Have you had your gallbladder removed?	( )	( )		
Have you had your appendix removed?	( )	( )		
Have you had a colectomy?	( )	( )		
Have you had a hysterectomy?	( )	( )		

WITHIN THE LAST YEAR	Type	Date	Where was it performed?
Surgeries			
☐ **None**			
Hospitalizations			
☐ **None**			
CT, MRI or Ultrasound			
☐ **None**			

ENDOSCOPY PROCEDURES	No	Yes	If yes, when?	Where was it performed?
Have you had a colonoscopy?	( )	( )		
Have you had a sigmoidoscopy (flex sig)?	( )	( )		
Have you had an EGD (upper endoscopy)?	( )	( )		

First Name Middle Int. Last Name

Month Day Year
Birthdate

Allergies & Sensitivities
(tape, latex, medications and foods) ☐ **None**

Allergens	Reactions
☐ Adhesive Tape	
☐ Amoxicillin	
☐ Aspirin	
☐ Augmentin	
☐ Codeine	
☐ Erythromycin	
☐ Hydrocodone	
☐ Latex	
☐ Meperidine HCL	
☐ Morphine	
☐ Penicillin	
☐ Sulfa	
☐ Tylenol	
☐ Other	

Family Medical History (blood relatives):
Check the box for conditions that apply. ☐ **None** ☐ **Adopted**

Condition	Parents		Siblings		Children	
	Mother	Father	Sister	Brother	Daughter	Son
Pancreatic cancer	( )	( )	( )	( )	( )	( )
Hepatitis	( )	( )	( )	( )	( )	( )
Cirrhosis	( )	( )	( )	( )	( )	( )
Crohn's disease	( )	( )	( )	( )	( )	( )
Gallstones	( )	( )	( )	( )	( )	( )
Ulcerative colitis	( )	( )	( )	( )	( )	( )
Age diagnosed with Colon/Rectal polyps	____	____	____	____	____	____
Age diagnosed with Colon/Rectal cancer	____	____	____	____	____	____

Vaccinations: Have you received any of the following? ☐ **None**

Vaccine	Date received
Hepatitis A	
Hepatitis B	
Pneumonia	
Influenza	
Shingles (Zostavax)	

Blood thinners: Are you taking any of the following blood thinners?
☐ **None**

Medication	No	Yes
Aspirin	( )	( )
Coumadin (warfarin)	( )	( )
Eliquis	( )	( )
Plavix	( )	( )
Pradaxa	( )	( )
Xarelto	( )	( )

Medications (including over the counter dietary supplements and prescription) ☐ **None**

Name and location of your preferred pharmacy: _____

Medication	Dose	How often do you take?	Do you need a refill?

First Name Middle Int. Last Name

Month Day Year
Birthdate

Personal Habits: Select the answers that best apply to you.

Which best describes your use of tobacco products? never / in the past / currently

If you currently use or have formerly used tobacco, what type? chew / cigar / cigarette /pipe / snuff / other

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Which best describes your alcohol consumption? never / in the past / currently

If you currently or have formerly consumed alcohol, what type? beer / wine / liquor

If you currently drink alcohol, how often? daily / weekly / monthly / occasionally

What is the average number of drinks you have when drinking? (write in number) _____

When was your last drink? _____

What is your marital status? married / partner / separated / divorced / single / widow

What is your occupation? _____

Recent Symptoms (Within the last 30 days)

CONSTITUTIONAL	No	Yes
chills, fevers, sweats	( )	( )
weight loss	( )	( )

EYES	No	Yes
change in vision	( )	( )

EARS/NOSE/THROAT	No	Yes
lump in throat	( )	( )
drainage back of throat	( )	( )

RESPIRATORY	No	Yes
persistent cough	( )	( )
shortness of breath	( )	( )

CARDIOVASCULAR	No	Yes
pain, pressure in chest	( )	( )
swelling in feet or ankles	( )	( )
irregular or rapid heart	( )	( )

GASTROINTESTINAL	No	Yes
difficulty swallowing	( )	( )
red rectal bleeding	( )	( )
black stools	( )	( )
diarrhea	( )	( )
constipation	( )	( )
recent change in bowels	( )	( )
abdominal pain	( )	( )
nausea	( )	( )
vomiting	( )	( )
heartburn	( )	( )

GENITOURINARY	No	Yes
burning urination	( )	( )
frequent urination	( )	( )
passed blood in urine	( )	( )

WOMEN ONLY	No	Yes
abnormal menstrual periods	( )	( )

BE SURE TO TELL US IF YOU ARE PREGNANT OR BECOME PREGNANT.

NERVOUS SYSTEM	No	Yes
frequent headaches	( )	( )
loss of strength	( )	( )

PSYCHIATRIC	No	Yes
anxiety	( )	( )
depression	( )	( )

SKIN	No	Yes
skin rashes	( )	( )
itching	( )	( )

MUSCULOLSKELETAL	No	Yes
joint pain or stiffness	( )	( )
back pain	( )	( )

Other Medical Problems Not listed

_____

_____

_____

_____

_____

_____

Patient or Legal Representative Signature Today's Date