

Please answer all questions, as this will become part of your medical history.

Patient Name _____ Appt Date _____
 Referring Physician _____ Date of Birth _____
 Primary Physician _____ Age _____

Drug Allergies ☐ No known drug allergies

Drug	Reaction	Drug	Reaction
1. _____	_____	6. _____	_____
2. _____	_____	7. _____	_____
3. _____	_____	8. _____	_____
4. _____	_____	9. _____	_____
5. _____	_____	10. _____	_____

What is the chief symptom or problem for which you have come to be evaluated?

Please list any additional or associated symptoms you are having with this illness:

When did the problem begin? _____

Please report any unusual circumstances or events at the time the problem began:

How severe are your symptoms? _____

Are your symptoms intermittent or continuous? _____

How often do you experience these symptoms? _____

How long do the symptoms last? _____

When or under what circumstances do you experience symptoms?

What brings on or aggravates your symptoms?

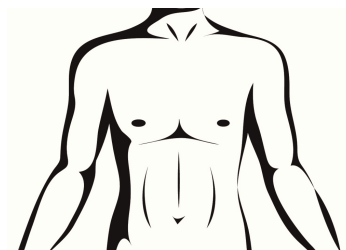
(e.g. eating, bowel movements, specific positions, activities, stress...)

What helps relieve your symptoms?

(e.g. eating, bowel movements, specific positions, relaxation, medicines...)

Is the severity or frequency of your symptoms worsening, stable or improving?

Please indicate on the diagram where your symptoms are located:



Physician Use Only

If the problem has been pain, how would you describe its character (e.g. burning, cramping, dull, sharp etc.)

What diagnostic tests or procedures have been done and what were the results?

1. _____ 3. _____
 2. _____ 4. _____

What medicines or treatments have you tried and did they help?

1. _____ 3. _____
 2. _____ 4. _____

Please list all your other current medical problems and diagnoses.

1. _____ 3. _____
 2. _____ 4. _____

Please list all your current medications, dosages and how often you take them. Please print or bring medicines with you to your appointment.

Drug	Strength	How Often

Drug	Strength	How Often

Pharmacy Name _____ Pharmacy Zip _____

Past Medical History

Surgical Operations and Hospitalizations

- | | | |
|-----------------------------------------------------|----------------------------------------------|------------------------------------------|
| Have you ever had a colonoscopy or upper endoscopy? | <input type="checkbox"/> Yes | If yes, when? _____ |
| Have you had colon polyps in the past? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had colon cancer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever had an ulcer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been given a blood transfusion? | <input type="checkbox"/> Yes | If yes, when? _____ |
| Have you been diagnosed with: | | |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Barrett's Esophagus | |
| Do you have a pacemaker / defibrillator? | <input type="checkbox"/> Yes | If yes, who placed it? _____ |

Family History

Which of your relatives (if any) have had the following conditions?

- | | | |
|-----------------------------------------------------------|---------------------|--------------------|
| <input type="checkbox"/> Colon Cancer | Family Member _____ | At what age? _____ |
| <input type="checkbox"/> Colon Polyps | Family Member _____ | At what age? _____ |
| <input type="checkbox"/> Ulcerative Colitis | Family Member _____ | |
| <input type="checkbox"/> Crohn's Disease | Family Member _____ | |
| <input type="checkbox"/> Liver Disease / Cirrhosis | Family Member _____ | |
| <input type="checkbox"/> Pancreatic Cancer / Pancreatitis | Family Member _____ | |
| <input type="checkbox"/> Other Diseases in Family | _____ | |

Social History / Personal Information

What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How many children do you have? _____

What is your occupation? _____

Have you been under an unusually large amount of stress lately? ☐ Yes ☐ No

Tobacco Use: ☐ Never Smoked ☐ Current Smoker ☐ Previous Smoker ☐ Current Chew / Dip
 Pack / Day _____ Year Quit _____

Alcohol Use: ☐ Yes ☐ No Drinks / Day _____

Review of Systems

Please check if you have RECENTLY had any of the following:

- ☐ Fever
- ☐ Weight Loss (Amount _____)
- ☐ Weight Gain (Amount _____)

Eyes / Throat

- ☐ Eye Irritation
- ☐ Hoarseness

Respiratory

- ☐ Cough
- ☐ Shortness of Breath / Wheezing

Cardiovascular

- ☐ Chest Pain
- ☐ High Blood Pressure

Gastroenterology

- ☐ Abdominal Pain
- ☐ Black, Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Yellow Skin or Jaundice

- ☐ Nausea / Vomiting
- ☐ Vomiting Blood

Urinary Tract

- ☐ Difficulty Urinating
- ☐ Kidney Stones

Musculoskeletal

- ☐ Joint Pain

Neurological

- ☐ Seizure
- ☐ Stroke

Psychiatric

- ☐ Feeling of Depression

Endocrine

- ☐ Thyroid Problems

Hematology

- ☐ Anemia or Low Blood Count
- ☐ Easy Bleeding / Hemophilia