

Patient Name: _____ DOB: _____ Today's Date: _____

Primary Care/Referring Physician: _____ Pharmacy _____

Reason for your visit today: _____

Medications (include medication name, dosage, and frequency and any over the counter medication)

Medication Allergies (include reactions)

TO BE COMPLETED BY CLINICAL STAFF AT TIME OF APPOINTMENT

Height: _____ Weight: _____ BP: _____ Pulse: _____ Temp: _____

Medical History

(Do you have or have you ever had)

- | | |
|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Coronary Artery Heart Disease |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Atrial Fibrillation |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Valvular Heart Disease |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Valve Replacement |
| <input type="checkbox"/> Reflux (GERD) | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Barrett's Esophagus | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Headaches (chronic) |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Failure |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Urinary Infections |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Anxiety Disorder |
| <input type="checkbox"/> Thyroid Disorders | <input type="checkbox"/> Seizure Disorder |

Other

Past Surgical History

- | | |
|--|---|
| <input type="checkbox"/> Gallbladder Removed | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Appendix Removed | <input type="checkbox"/> Lumpectomy |
| <input type="checkbox"/> Prostate Surgery | <input type="checkbox"/> Thyroid Surgery |
| <input type="checkbox"/> Prostatectomy | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Stomach _____ | <input type="checkbox"/> Hernia Repair |
| <input type="checkbox"/> Colon _____ | <input type="checkbox"/> Coronary Artery Bypass |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Implanted Device |
| <input type="checkbox"/> Orthopedic | <input type="checkbox"/> Pace Maker/Defibrillator |
| <input type="checkbox"/> Other: _____ | |

Family History (Parents and/or siblings)

- | | |
|---|--|
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Gallbladder Disease |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Pelvic Cancer |
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> Stomach Cancer | |

Social History

Alcohol Use

- Social Drinker Moderate (2 drinks/day or less)
 Heavy use Recovering Alcoholic

Smoking

- How many years? _____
 Packs per Day? _____
 Previous History of Smoking
 Illicit Drug Use Using Intravenous Drugs?
 Current Drug Use Past Drug Use

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Weight Change | <input type="checkbox"/> Cough | <input type="checkbox"/> Belching | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Sputum production | <input type="checkbox"/> Abdominal bloating | <input type="checkbox"/> Joint stiffness |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Muscle aches |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Increased urinary frequency | <input type="checkbox"/> Chronic headaches |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Frequent urination at night | <input type="checkbox"/> Eyesight problems |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Itching | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Nausea | <input type="checkbox"/> Skin rashes | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Numbness, tingling |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Excessive vaginal bleeding | <input type="checkbox"/> Sleep disturbances |
| <input type="checkbox"/> Regurgitation | <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Painful swallowing | <input type="checkbox"/> Constipation | <input type="checkbox"/> Easy bleeding | |
| <input type="checkbox"/> Lump in throat | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Swollen glands in neck | |
| <input type="checkbox"/> Chest pain or discomfort | <input type="checkbox"/> Black tarry stools | | |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Blood in stool | | |
| <input type="checkbox"/> Shortness of breath
With exertion | <input type="checkbox"/> Abdominal pain | | |
| <input type="checkbox"/> Leg cramps/pain | <input type="checkbox"/> Mucus in stool | | |

What tests, **RELATED TO WHY YOU ARE HERE**, have recently been done?
When?
Where?
Why?

EKG			
Chest X-Ray			
Upper GI (x-ray)			
Ultrasound of abdomen			
Barium enema (x-ray)			
CAT scan of abdomen			
MRI of abdomen			
Labs			

Have you **recently (within 1 year)** completed a 3-day stool card? _____ Result _____

Have you ***EVER*** had any of the following?

EGD (upper endoscopy, a tube is placed down your throat to look at the esophagus and stomach, you are sedated)

Yes () No ()

When? _____ Where? _____ Why? _____

Flexible Sigmoidoscopy (half of the colon is looked at with a tube, no sedation) Yes () No ()

When? _____ Where? _____ Why? _____

Colonoscopy (lower endoscopy, all of your colon is looked at with a tube, you are sedated) Yes () No ()

When? _____ Where? _____ Why? _____