

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

Pharmacy Name/Address/ Phone #: _____

Reason for your visit today: _____

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

Medication Allergies (include reactions)

TO BE COMPLETED BY CLINICAL STAFF AT TIME OF APPOINTMENT

Weight: _____ BP: _____ Pulse: _____ Respirations: _____

Medical History

(do you have or have you ever had)

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

Past Surgical History

- Gallbladder Removed
- Appendix Removed
- Stomach Surgery
- Colon Surgery
- Hysterectomy
- Orthopedic Surgery
- Other: _____
- Mastectomy
- Prostate Surgery
- Thyroid Surgery
- Radiation Therapy
- Hernia Repair
- Coronary Artery Bypass Surgery

Family History (Parents and/or siblings)

- Liver Disease
- Cirrhosis
- Colon Cancer
- Colon Polyps
- Ulcerative Colitis
- Stomach Cancer
- Crohn's Disease
- Gallbladder Disease
- Anemia
- Pelvic Cancer
- Breast 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 sweating | <input type="checkbox"/> Numbness, tingling |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Sleep disturbances |
| <input type="checkbox"/> Dentures (do you have) | <input type="checkbox"/> Regurgitation | <input type="checkbox"/> Excessive vaginal bleeding | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Dysphagia | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Painful swallowing | <input type="checkbox"/> Constipation | <input type="checkbox"/> Easy bruising | |
| <input type="checkbox"/> Lump in throat | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Easy bleeding | |
| <input type="checkbox"/> Chest pain or discomfort | <input type="checkbox"/> Black tarry stools | <input type="checkbox"/> Swollen glands in neck | |
| <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 | | |

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? _____

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			