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

Primary Care/Referring Physician: _____ **Pharmacy**_____

Reason for your visit today: _____
_____
_____
_____
_____

Medication Allergies (include reactions)
_____
_____
_____
_____

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

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)

( ) Anemia
( ) Coronary Artery Heart Disease
( ) 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
( ) 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

Other
_____
_____

Past Surgical History

( ) Gallbladder Removed
( ) Appendix Removed
( ) Prostate Surgery
( ) Prostatectomy
( ) Stomach_____
( ) Colon _____
( ) Hysterectomy
( ) Orthopedic
( ) Implanted Device
( ) Pace Maker/Defibrillator
( ) Mastectomy
( ) Lumpectomy
( ) Thyroid Surgery
( ) Radiation Therapy
( ) Hernia Repair
( ) Coronary Artery Bypass
( ) Other: _____

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?

( ) Weight Change
( ) Fever
( ) Chills
( ) Night Sweats
( ) Fatigue
( ) Earache
( ) Ringing in the ears
( ) Nosebleeds
( ) Mouth sores
( ) Bleeding gums
( ) Regurgitation
( ) Hoarseness
( ) Painful swallowing
( ) Lump in throat
( ) Chest pain or discomfort
( ) Palpitations
( ) Shortness of breath With exertion
( ) Leg cramps/pain

( ) Cough
( ) Sputum production
( ) Coughing up blood
( ) Wheezing
( ) Shortness of breath
( ) Bad breath
( ) Anorexia
( ) Nausea
( ) Vomiting
( ) Heartburn
( ) Excessive sweating
( ) Difficulty Swallowing
( ) Constipation
( ) Diarrhea
( ) Black tarry stools
( ) Blood in stool
( ) Abdominal pain
( ) Mucus in stool

( ) Belching
( ) Abdominal bloating
( ) Painful urination
( ) Increased urinary frequency
( ) Frequent urination at night
( ) Blood in urine
( ) Itching
( ) Skin rashes
( ) Excessive thirst
( ) Excessive vaginal bleeding
( ) Hair loss
( ) Easy bruising
( ) Easy bleeding
( ) Swollen glands in neck

( ) Joint pain
( ) Joint stiffness
( ) Muscle aches
( ) Chronic headaches
( ) Eyesight problems
( ) Dizziness
( ) Fainting
( ) Muscle Weakness
( ) Numbness, tingling
( ) Sleep disturbances
( ) Anxiety
( ) Depression

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? _____

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