Primary Care/Referring Physician:	Reason for your visit today:		DOB: _	Today's Date:		
Medication Allergies (include reactions)    Medication Allergies (include reactions)			Pharmacy			
Medical History   Past Surgical History   Go you have or have you ever had)   () Coronary Artery Heart Disease   () Colon Cancer () Congestive Heart Failure () Colon Cancer () Valval Fibrillation () Valve Replacement () High Cholesterol () Crohn's Disease () Headaches (chronie) () Irritable Bowel () Stroke () High Blood Pressure () Colon Cancer () Removed () High Blood Pressure () Colon Congestive Heart Failure () Colon () Radiation Therapy () Headaches (chronie) () Irritable Bowel () Stroke () Emily History (Parents and/or siblings) () Hepatitis C () Rheumatoid Arthritis () Colon Colon Colon Siblings () High Blood Pressure () Colon Colon Colon () Radiation Therapy () Hepatitis C () Rheumatoid Arthritis () Colon Colon () Radiation Therapy () Hepatitis C () Rheumatoid Arthritis () Colon Colon () Crohn's Disease () Coronary Artery Bypass () Disease () Cirrhosis () Gallbladder Disea				and any over the counter medication)		
Medical History						
Medical History			ED BV CLINICA			
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Medical History	Height:	Weight:	BP:	Pulse:	Temp:	
Medical History						
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ARE YO	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 bleedin ( ) 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 <b>recently (within 1 year)</b> completed a 3-day stool card? Result									
	e is placed down your throat t	to look at the esophagus and ston	nach, you are sedated)						
Yes ( ) No ( ) When? Where?	No ( ) Where? Why?								
Flexible Sigmoidoscopy (half of the colon is looked at with a tube, no sedation) Yes ( ) No ( ) When? Why?									
		at with a tube, you are sedated) Why?							