Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Patient History

Please answer every question.

STAFF: Responses in boxes and handwritten items must be entered **MANUALLY**.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

PLEASE BRING ALL OR A LIST OF YOUR CURRENT MEDICATIONS TO YOUR VISIT.

Date: / /

Maiden Name (if applicable)**:**

SSN: / /

Gender:

Height:

Weight:

Address:

City:

State:

Zip:

Primary #: ( )

Secondary #: ( )

Work #: ( )

Emergency Contact / Relationship:

Phone #: ( )

Primary Care Physician:

Referred by:

Email Address:

What is the purpose of your visit?

Which pharmacy do you use? (Include location and phone number if known.)

Race:
American Indian or Alaskan Native ◯
Hawaiian or other Pacific Islander ◯
Black or African American ◯
Asian ◯
White ◯
other ◯
unknown ◯

Ethnicity: Hispanic or Latino ◯ Non-Hispanic or Latino ◯ unknown ◯

Marital status: married ◯ single ◯ divorced ◯ widowed ◯

ALLERGIES

Please list any medication / item you are allergic to: (For more space, turn page over.)

◯ NO KNOWN ALLERGIES ◯ NO KNOWN DRUG ALLERGIES

Medication / Item	Reaction it causes	Medication / Item	Reaction it causes

Previous anesthesia complications:

PROCEDURES

Please indicate when you last had each of the applicable tests:

Results were:

	N/A	1 year or less	2 years ago	3 years ago	4 years ago	5 years ago	6 years ago	7 years ago	8 years ago	9 years ago	10+ years ago	Normal	Abnormal	Don't Know
Colonoscopy	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Flexible Sigmoidoscopy	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Upper Endoscopy	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
ERCP (endoscopic retrograde cholangiopancreatography)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
EUS (endoscopic ultrasound)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
CT Scan of Abdomen or GI tract	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Ultrasound of Abdomen or GI tract	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Patient History

Please answer every question.

SOCIAL HISTORY

Occupation: _____ Employer: _____

Employment status:	full time ◯	part time ◯	unemployed ◯	retired ◯
Student status:		full time ◯	part time ◯	n/a ◯
Do you have an Advanced Directive / Living Will?			yes ◯	no ◯

TOBACCO USE

How would you describe your cigarette smoking?	current (every day) ◯								previous ◯
	current (some days) ◯								never ◯
How many packs per day do you (or did you) smoke?	less than 1 ◯			1-2 ◯					more than 2 ◯
How many years have you (or did you) smoke?	less than 5 ◯	5 ◯	10 ◯	15 ◯	20 ◯	25 ◯	30 ◯	35 ◯	40+ ◯
Does anyone in your household smoke?					yes ◯				no ◯
Do you use other tobacco products?	currently ◯				in the past ◯				never ◯

ALCOHOL USE

Do you consume alcohol?	currently ◯	in the past ◯	never ◯
Average number of drinks per week (now or in the past)?	7 or less ◯	8-14 ◯	15 or more ◯

IV drug use or other recreational drug use?	currently ◯	in the past ◯	never ◯
Have you ever had a blood transfusion?		yes ◯	no ◯
Have you had any recent foreign travel?		yes ◯	no ◯
Do you have any body piercings?		yes ◯	no ◯
Do you have any tattoos?		yes ◯	no ◯

GASTROINTESTINAL CONDITIONS

Please indicate if YOU have a history of the following:

PAST	CURRENT		PAST	CURRENT	
◯	◯	Acid Reflux / GERD	◯	◯	Gallbladder Problems
◯	◯	Alcohol Abuse	◯	◯	Gastrointestinal Bleeding
◯	◯	Anal Fissure	◯	◯	Hemorrhoids
◯	◯	Barrett's Esophagus	◯	◯	Hepatitis A
◯	◯	Bowel Obstruction	◯	◯	Hepatitis B
◯	◯	Celiac Disease or Sprue	◯	◯	Hepatitis C
◯	◯	Chronic Constipation	◯	◯	Hiatal Hernia
◯	◯	Chronic Diarrhea	◯	◯	H. Pylori
◯	◯	Cirrhosis / Liver Failure	◯	◯	Irritable Bowel Syndrome (IBS)
◯	◯	Colon Polyps	◯	◯	Liver Failure
◯	◯	Crohn's Disease	◯	◯	Pancreatitis
◯	◯	Diverticulitis	◯	◯	Stomach or Duodenal Ulcer
◯	◯	Diverticulosis	◯	◯	Ulcerative Colitis

◯ **NO GASTROINTESTINAL HISTORY**

◯ Other Gastrointestinal condition (please specify): _____

_____

SURGICAL HISTORY

Please mark all surgeries you have had:

◯ Appendectomy	◯ Gallbladder	◯ Kidney Transplant	◯ Splenectomy
◯ Back	◯ Heart Bypass	◯ Liver Transplant	◯ Stomach
◯ Brain	◯ Heart Valve Replacement	◯ Lysis of Adhesions	◯ Weight Loss
◯ Breast	◯ Heart / Vascular Stents	◯ Pacemaker	◯ Other Surgery (please specify)):
◯ Cataract	◯ Hernia	◯ Pancreatic	_____
◯ Colon / Bowel	◯ Hysterectomy	◯ Prostate	_____
◯ Defibrillator	◯ Joint Replacement	◯ Reflux	◯ **I HAVE HAD NO SURGERIES**

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Patient History

Please answer every question.

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YOUR MEDICAL HISTORY

Please indicate if YOU have a history of the following:

- ◯ Anemia
- ◯ Anxiety
- ◯ Arthritis
- ◯ Artificial Heart Valve
- ◯ Asthma
- ◯ Bladder Infections
- ◯ Blood Clots
- ◯ Chronic Pain
- ◯ Clotting or Bleeding Disorder
- ◯ Congestive Heart Failure
- ◯ COPD or Emphysema
- ◯ Deaf / Hard of Hearing
- ◯ Degenerative Neurologic Disease
- ◯ Depression
- ◯ Diabetes Type 1
- ◯ Diabetes Type 2 (adult onset)
- ◯ Fibromyalgia
- ◯ Glaucoma
- ◯ Heart Attack
- ◯ Heart Murmur
- ◯ Heart Valve Problems
- ◯ High Cholesterol or Triglycerides
- ◯ Home Oxygen
- ◯ High Blood Pressure
- ◯ HIV
- ◯ Irregular Heartbeat
- ◯ Kidney Infections
- ◯ Legally Blind
- ◯ Lupus
- ◯ Migraines
- ◯ Osteoporosis
- ◯ Post Traumatic Stress Disorder
- ◯ Prostate Problems
- ◯ Psychiatric Disorder
- ◯ Recent Respiratory Tract Infection
- ◯ Rheumatoid Arthritis
- ◯ Seasonal Allergies
- ◯ Seizures
- ◯ Sinus Problems
- ◯ Sleep Apnea
- ◯ CPAP
- ◯ Stroke
- ◯ Thyroid Disease
- ◯ Other Disease or Significant Medical Illness (please specify):

  _____

  _____
- ◯ **NO MEDICAL HISTORY**

CANCER

Please indicate if YOU have a history of any type(s) of cancer:

- ◯ Blood (e.g., Leukemia)
- ◯ Breast
- ◯ Colon
- ◯ Esophageal
- ◯ Liver
- ◯ Lungs
- ◯ Mouth
- ◯ Ovarian
- ◯ Pancreatic
- ◯ Prostate
- ◯ Rectal
- ◯ Skin
- ◯ Stomach
- ◯ Throat
- ◯ Uterine
- ◯ Chemotherapy
- ◯ Radiation Therapy
- ◯ Other Cancer (please specify):

  _____
- ◯ **NO CANCER HISTORY**

FAMILY MEDICAL HISTORY

◯ **Family History UNKNOWN** ◯ **ADOPTED**

Please indicate which family member(s) have had these illnesses.	Brother	Sister	Father	Mother	Grandfather *Mother's side*	Grandmother *Mother's side*	Grandfather *Father's side*	Grandmother *Father's side*
Autoimmune Hepatitis	◯	◯	◯	◯	◯	◯	◯	◯
Bleeding Disorder	◯	◯	◯	◯	◯	◯	◯	◯
Blood Clots	◯	◯	◯	◯	◯	◯	◯	◯
Breast Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Celiac Disease	◯	◯	◯	◯	◯	◯	◯	◯
Colon Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Colon Polyps	◯	◯	◯	◯	◯	◯	◯	◯
Crohn's Disease	◯	◯	◯	◯	◯	◯	◯	◯
Diabetes Type 1	◯	◯	◯	◯	◯	◯	◯	◯
Diabetes Type 2 (adult onset)	◯	◯	◯	◯	◯	◯	◯	◯
Esophageal Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Gallstones	◯	◯	◯	◯	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯	◯	◯	◯	◯
Hemochromatosis	◯	◯	◯	◯	◯	◯	◯	◯
Liver Disease	◯	◯	◯	◯	◯	◯	◯	◯
Pancreatic Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Prostate Cancer	◯		◯		◯		◯	
Sickle Cell	◯	◯	◯	◯	◯	◯	◯	◯
Stomach Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Stomach Ulcer	◯	◯	◯	◯	◯	◯	◯	◯
Stroke	◯	◯	◯	◯	◯	◯	◯	◯
Ulcerative Colitis	◯	◯	◯	◯	◯	◯	◯	◯
Cancer (other)	◯	◯	◯	◯	◯	◯	◯	◯

◯ **NO SIGNIFICANT FAMILY HISTORY**