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♠ Direction of Feed **♠**

Patient Medical History

Please answer every question

PLEASE PRINT PATIENT'S LAST NAME

STAFF: Responses in boxed bubbles and handwritten items must be entered MANUALLY.

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Marking	Instructions
MINI KILLE	III3ti actions

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



PLE	ASE	PRI	NT P	ATIE	NT'	S FIR	ST N	IAM	E		PAT	IENT	'S D	ATE	OF B	BIRTH	1	

	pplete this history form. This will herein is strictly confidential and			re us to do so.			
PATIENT MEDICAL HISTORY	Mark all conditions that you h	ave had. If you have	had none in a cat	tegory, mark NONE.			
GASTROINTESTINAL CONDITIONS Celiac Disease or Sprue Gastrointestinal Bleeding Irritable Bowel Syndrome (IBS) Yellow Skin / Jaundice	Helicobacter Pylori (H. Intestinal Infection Bowel Obstruction Acid Reflux / GERD Liver Failure / Cirrhosi	. pylori) An Co Div	Ilbladder Problems al Fissure Ion Polyps verticulitis verticulosis ohn's Disease	Hiatal Hernia Pancreatitis Hemorrhoids Hepatitis A Hepatitis B Hepatitis C			
Stomach Ulcer / Duodenal Ulcer Esophageal Stricture / Narrowing	Barrett's Esophagus Chronic Constipation	Uld Ald	cerative Colitis cohol Abuse	Other NONE			
NON-GASTROINTESTINAL CONDIT Congestive Heart Failure Hardening of the Arteries Heart Disease / Heart Attack Treatment with Blood Thinner Abnormal Heartbeat / Palpitations Esophageal CANCER Mouth / Throat Colon / Rectal	Antibiotic Treatment within the Past 2 Mon HIV Exposure Seizure Disorder Multiple Sclerosis (MS	Em ths	gh Blood Pressure sphysema / COPD lney Disease sbetes sod Clots / Positive romyalgia Lungs Uterine Breast	Thyroid Disease Lupus Stroke Anemia Arthritis Asthma NONE Liver Other NONE			
FAMILY HISTORY Family History Unknown	Fill in the oval if a relative has Adopted	had one of the follow		○ NONE			
Prostate Cancer Cirrl Stomach Cancer Celia	nosis Crol ac Disease Ulce	rian Cancer hn's Disease erative Colitis cer, Other	Liver Failure Liver Cancer Heart Attack Hypertension	Stroke Diabetes Sickle Cell Gallstones			
Please fold on dotted line Hemochromatosis Alcohol Abuse Blood Clots Ulcer Disease Hepatitis B Autoimmune Hepatitis Uterine Cancer Pancreatitis Tuberculosis (TB) Hepatitis C							
	s had Colorectal Cancer? ve developed condition, if known s 40's 50's 60's 70's 80+			d Colon Polyps? loped condition, if known 50's 60's 70's 80+			
Mother O O O O O O O O O O O O O O O O O O O		Mother Father Sister Brother					



♠ Direction of Feed **♠**

Patient Medical History

Please answer every question

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



GENERAL night sweats fever unintentional weight tiredness lack of appetite loss (over 10 lbs) NONE HEAD, EARS, EYES, NOSE & THROAT wear contacts hoarseness decreased hearing NONE CARDIOVASCULAR heart stent swelling of hands or feet leg cramps elevated blood pressure fainting / blocking out NONE GENITOURINARY blood in urine painful urination urinary frequency NONE GENITOURINARY blood in urine painful urination urinary frequency NONE GENITOURINARY blood in urine painful urination urinary frequency NONE GENITOURINARY blood in urine painful urination urinary frequency NONE ENDOCRINE cold intolerance excessive thirst excessive urination NONE ENDOCRINE backache joint stiffness physical disability NONE SKIN itching rash NONE SKIN itching rash NONE SKIN itching rash NONE SKIN itching rash NONE SEPSYCHIATRIC suicidal thoughts depression anxiety NONE BLOOD breast mass breast mass breast pain NONE BLOOD breast pain NONE BLOOD breast pain NONE BLOOD breast painful swallowing breast painfu		ACTIVE SYMPTOMS pply. If you have no sy					Patient I	Name:	
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Has your stool tested positive for blood in the past 6 months? NO YES	bloating 🔵	change in boy	vel habits 🔵	stool i	ncontinence		blood in stool		laxative use
NO YES	vomiting O	painful bowel m	ovement 🔘	abdom	inal swelling		gas / flatulence		NONE (
NO YES Colonoscopy Date: Findings: Findings: Flexible Sigmoidoscopy Date: Findings:	las your stool	tested positive for bloc	d in the past	t 6 months?		no	yes		
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Automatic Cardiac Defibrillator Breast Augmentation Colon Resection Other					t				
OTHER PAST OPERATIONS OR MEDICAL PROBLEMS (Not noted elsewhere in this form.)									
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REFERRING DOCTOR PRIMARY DOCTOR	REEEBBING	DOCTOR			DRIMAG	א טע	OCTOR		
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Page 2 of 3

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♠ Direction of Feed **♠**

Patient Medical History

Please answer every question

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

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PERSONAL AND SOCIAL H	ISTORY			Pati	ent Name:		
ALCOHOL USE							
Do you consume alcohol?			never 🤇	in the	past 🔘	currently	
Average number of drinks	s per week (n	ow or in past)?	7 or less 🤇		8-14 🔵	15 or more	
TOBACCO USE				never 🔘	curr	ently (every day)	
How would you describe	your cigarett	e smoking?	in	the past 🔘	curre	ently (some days)	
How many packs per day	do you (or did	you) smoke?	less than 1	1-2	$\overline{\bigcirc}$	more than 2	
How many years have you			5 or less	6-10		more than 10	
Do you use other tobacco			iever 🔘	in the past	$\tilde{\bigcirc}$	currently	$\overline{\bigcirc}$
CAFFEINE USE	p . • • • • • • • • • • • • • • • • • • •			occas	ional (1-2	$\overline{\frown}$
How many caffeinated be	verages do v	ou consume ner da	v? none 🤇		3-5	more than 5	\overline{a}
OTHER	verages as y	ou consume per uu	y. Hone		330	in the past	\exists
IV drug use or other recre	ational drug	uco2		never		currently	
Have you engaged in high				Hevel		in the past	
		-	•				
transmitted diseases (anal	sex, unprotecte	d sex, multiple partners):		never	$\overline{}$	currently	=
Have you ever had a bloo Have you had any recent Do you have any body pie Do you have any tattoos? Do you live alone?	foreign trave ercings?				yes yes yes yes	no no no no	00000
,							
MEDICATION ALLERGIES If possible, include your reactions Medication or Injection PRESCRIPTION MEDICATION	Please list (e.g., hives, we Reaction	se list all prescriptio	mjections that have aches, nausea, diarri Medication or Injection medications you ate list to your appoint	nea, passed out,	d reactions shock, shor Reaction	nesthesia	tc.)
		please fold on			• • • • • • • • • • • • • • • • • • • •		• • • • • • • • • • • • • • • • • • • •
Name of Medication	Dosage	Frequency	Name of Medication	n D	osage	Frequency	
OVER-THE-COUNTER MED		Please list all ove spirin, Motrin, Tagame			re current	ly taking.	
Name of Medication	Dosage	Frequency	Name of Medication	n D	osage	Frequency	
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