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Adult Patient Medical History

Please answer every question

STAFF: *Responses in boxed bubbles 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

REASON FOR VISIT

YOUR MEDICAL HISTORY

Please indicate if you have a history of the following. Mark all that apply.

GASTROINTESTINAL CONDITIONS

- Barrett's Esophagus
- Esophageal Stricture or Narrowing
- Esophageal Varices
- Colon Polyps
- Crohn's Disease
- Colitis / Ulcerative
- Alcohol Abuse
- Hepatitis A
- Hepatitis B

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- Acid Reflux / GERD
- Helicobacter Pylori Infection (H. pylori)
- Stomach Ulcer or Duodenal Ulcer
- Celiac Disease or Sprue
- Chronic Constipation
- Irritable Bowel Syndrome (IBS)
- Gastrointestinal Bleeding
- Intestinal Infection
- Bowel Obstruction
- Diverticulosis
- Diverticulitis
- Hemorrhoids
- Anal Fissure
- Eating Disorders
- Jaundice (Yellow Skin)
- Liver Failure / Cirrhosis
- Hepatitis C
- Gallbladder Problems
- Pancreatitis
- Other (please specify): _____
- **NONE**

NON-GASTROINTESTINAL CONDITIONS

- High Blood Pressure
- Emphysema or COPD
- Sleep Apnea
- Congestive Heart Failure
- Hardening of the Arteries
- Abnormal Heartbeat / Palpitations
- Treatment with Blood Thinner
- Heart Disease / Heart Attack
- Antibiotic Treatment (within past 2 months)
- High Cholesterol / Triglycerides
- Autoimmune Disease
- Glaucoma
- Multiple Sclerosis (MS)
- HIV Positive
- HIV Exposure
- Thyroid Disease
- Seizure Disorder
- Bleeding Disorder
- Lupus
- Alzheimer's / Dementia
- Stroke
- Mental Illness
- Depression
- Physical or Sexual Abuse
- Endometriosis
- Heart Murmur
- Asthma
- Anemia
- Diabetes
- Fibromyalgia
- Blood Clots
- Rheumatic Fever
- Kidney Failure
- Other (please specify): _____
- **NONE**

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CANCER

- Mouth / Throat
- Esophageal
- Stomach
- Colon or Rectal
- Pancreatic
- Blood (e.g., Leukemia)
- Prostate
- Lung
- Breast
- Uterine
- Ovarian
- Skin
- Other (please specify): _____
- **NONE**

FAMILY HISTORY

Have any of your blood relatives had Colorectal Cancer?

	YES	NO	Age relative developed condition, if known: 20's	30's	40's	50's	60's	70's	80+
Grandparent									
Parent									
Brother / Sister									
Child									
Aunt / Uncle									

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Adult Patient Medical History

Please answer every question

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

Patient name: _____

FAMILY HISTORY

Please indicate if a FAMILY MEMBER has had any of the following.
(Include parents, grandparents, siblings, offspring, aunts and uncles.)

- ◯ Autoimmune Hepatitis
- ◯ Celiac Disease
- ◯ Colon Polyps
- ◯ Crohn's Disease
- ◯ Gallstones
- ◯ Hemochromatosis
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ Irritable Bowel Syndrome (IBS)
- ◯ Liver Cancer
- ◯ Liver Failure
- ◯ Pancreatitis
- ◯ Stomach Cancer
- ◯ Ulcerative Colitis
- ◯ Ulcer Disease
- ◯ Alcohol Abuse
- ◯ Bleeding Disorder
- ◯ Blood Clots
- ◯ Breast Cancer
- ◯ Diabetes
- ◯ Heart Attack
- ◯ High Blood Pressure
- ◯ Mental Illness
- ◯ Ovarian Cancer
- ◯ Prostate Cancer
- ◯ Sickle Cell
- ◯ Stroke
- ◯ Tuberculosis (TB)
- ◯ Uterine Cancer
- ◯ Other (please specify): _____ _____
- ◯ **NONE**

please fold on dotted line

SOCIAL HISTORY

Marital status: ◯ married ◯ single ◯ divorced ◯ widowed

Do you live alone? ◯ yes ◯ no

ALCOHOL USE

Do you consume alcohol? ◯ never ◯ in the past ◯ currently

Average number of drinks per week (now or in the past)? ◯ 7 or less ◯ 8-14 ◯ 15 or more

TOBACCO USE

How would you describe your cigarette smoking?
◯ never ◯ in the past ◯ current (some days) ◯ current (every day)

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? ◯ 5 or less ◯ 6-10 ◯ more than 10

Do you use other tobacco products? ◯ never ◯ in the past ◯ currently

How many caffeinated beverages do you consume per day?
◯ none ◯ occasional ◯ 1-2 ◯ 3-5 ◯ more than 5

Recent foreign travel? ◯ yes ◯ no

IV drug use or other recreational drug use?
◯ never ◯ in the past ◯ currently ◯ prefer to discuss with doctor

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Have you engaged in high risk behavior for sexually transmitted diseases?
(e.g., anal sex, homosexual activity, multiple sex partners, etc.)
◯ never ◯ in the past ◯ currently ◯ prefer to discuss with doctor

Have you ever had a blood transfusion? ◯ yes ◯ no

Do you have a tattoo(s)? ◯ yes ◯ no

Do you have a body piercing(s)? ◯ yes ◯ no

CURRENT CONDITIONS

Do you currently have any of these symptoms or conditions? Mark all that apply. If no symptoms, mark "NONE".

GENERAL

- ◯ fatigue
- ◯ night sweats
- ◯ appetite loss
- ◯ sleep disturbance
- ◯ chills / fever
- ◯ weight loss
- ◯ weight gain
- ◯ **NONE**

Adult Patient Medical History

Please answer every question

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

CURRENT CONDITIONS continued

Mark all that apply. If no symptoms, mark "NONE".

Patient name: _____

GASTROINTESTINAL

- ◯ heartburn / indigestion / reflux
- ◯ difficulty swallowing
- ◯ painful swallowing
- ◯ abdominal pain
- ◯ nausea
- ◯ vomiting
- ◯ get full quickly at meals
- ◯ abdominal distention
- ◯ gas / flatulence
- ◯ bloating
- ◯ laxative use
- ◯ pain with bowel movement
- ◯ hemorrhoids
- ◯ belching
- ◯ irregular bowel habits
- ◯ diarrhea
- ◯ constipation
- ◯ stool incontinence
- ◯ black stools
- ◯ blood in stool
- ◯ jaundice / yellow skin color
- ◯ vomiting blood
- ◯ hernia
- ◯ food / milk intolerance
- ◯ **NONE**

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Has your stool tested positive for blood? yes ◯ no ◯

Have you ever had an x-ray, CT or ultrasound of your abdomen or GI tract? yes ◯ no ◯

NEUROLOGICAL

- ◯ frequent headaches
- ◯ fainting
- ◯ convulsions or seizures
- ◯ dizziness
- ◯ **NONE**

CARDIOVASCULAR

- ◯ chest pain or pressure (after eating or when upset)
- ◯ chest pain or pressure with exertion (angina)
- ◯ irregular heart rate / palpitations
- ◯ leg swelling
- ◯ **NONE**

RESPIRATORY

- ◯ shortness of breath
- ◯ wheezing
- ◯ chronic cough
- ◯ coughing up sputum
- ◯ chronic or frequent hoarseness
- ◯ tuberculosis exposure (TB)
- ◯ spitting up blood
- ◯ **NONE**

GENITOURINARY

- ◯ kidney stones
- ◯ frequent urinary infections
- ◯ blood in urine
- ◯ prostate problems
- ◯ painful / difficult urination
- ◯ frequent urination
- ◯ incontinence
- ◯ **NONE**

FEMALES ONLY

- ◯ heavy menstrual periods
- ◯ Are you or could you be pregnant?
- ◯ painful menstrual periods
- ◯ **NONE**

PSYCHOSOCIAL

- ◯ usually feel lonely or depressed
- ◯ anxiety
- ◯ stress
- ◯ **NONE**

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SKIN

- ◯ severe itching
- ◯ rash
- ◯ change in hair or nails
- ◯ unusual mole(s)
- ◯ flushing
- ◯ **NONE**

BONE & JOINT

- ◯ arthritis
- ◯ joint pain
- ◯ back pain
- ◯ **NONE**

BLOOD

- ◯ easy bruising
- ◯ excessive bleeding
- ◯ enlarged or painful lymph nodes
- ◯ **NONE**

EYES

- ◯ blurred / double vision
- ◯ glasses or contacts
- ◯ eye disease
- ◯ **NONE**

EARS / NOSE / THROAT

- ◯ nose or gums bleeding
- ◯ bad breath or bad taste in mouth
- ◯ mouth sores
- ◯ **NONE**

ENDOCRINE

- ◯ cold intolerance
- ◯ heat intolerance
- ◯ **NONE**

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Adult Patient Medical History

Please answer every question

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

Do you have an advance directive? yes ◯ no ◯

If yes, do we have a copy? yes ◯ no ◯

Patient name: _____

SURGERIES

Please mark all surgeries that you have had:

- ◯ **I Have Had NO SURGERIES**
- ◯ Adhesions
- ◯ Bariatric (Weight Loss)
- ◯ Colon
- ◯ Esophagus
- ◯ Gallbladder
- ◯ Hemorrhoids
- ◯ Hernia / Groin
- ◯ Laparoscopy
- ◯ Stomach
- ◯ Ulcer
- ◯ Aortic Aneurysm
- ◯ Appendix Removal
- ◯ Automatic Defibrillator
- ◯ Pacemaker
- ◯ Back / Spinal
- ◯ Brain
- ◯ Breast
- ◯ Coronary Stents
- ◯ Heart Bypass
- ◯ Heart Valve
- ◯ Hysterectomy
- ◯ Joint Replacement(s)
- ◯ Prostate
- ◯ Tonsils
- ◯ Transplant
- ◯ Tubal Ligation
- ◯ Other Implanted Device
- ◯ Other (please specify): _____

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PROCEDURES

Please indicate if you have had any of the following:

	YES	NO	Date (approximate) & findings:
Colonoscopy	◯	◯	
EGD (Upper Endoscopy)	◯	◯	
Flexible Sigmoidoscopy	◯	◯	
ERCP	◯	◯	

ALLERGIES

Please indicate if you have allergies to any of the following:

- ◯ **I Have NO KNOWN Allergies**
- ◯ Medication
- ◯ Latex / Rubber
- ◯ Anaphylactic or Other Reaction to Anesthesia
- ◯ Food
- ◯ Other (please specify): _____

Please list any MEDICATIONS or INJECTIONS that have given you bad reactions.
If possible, include your reactions (e.g., hives, welts, rash, itching, headaches, nausea, diarrhea, fainted, shock, shortness of breath, etc.)

◯ **I Have NO KNOWN Medication Allergies**

_____

Please list any FOODS that have given you bad reactions.
If possible, include your reactions (e.g., hives, welts, rash, itching, headaches, nausea, diarrhea, fainted, shock, shortness of breath, etc.)

_____

MEDICATIONS

Please list all medications you are currently taking.

Include **PRESCRIPTION** and **OVER THE COUNTER** medications. (e.g., aspirin, Advil, BC Powder®, Motrin, Tagamet-HB, vitamins, supplements, herbs, etc.)

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Name of Medication	Dosage	Frequency	Name of Medication	Dosage	Frequency

Occupation: _____ **Referring MD:** _____

Last Menstrual Period: _____ **Primary MD / OB-GYN:** _____

OTHER PAST MEDICAL PROBLEMS

Please list any other medical history not already covered in this questionnaire:

_____

_____

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