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

# Patient Medical History

Please answer every question.

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

## Marking Instructions

Please use a #2 pencil or a black pen.
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

## YOUR MEDICAL HISTORY

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

**Gastrointestinal Conditions**

- Chronic Constipation
- Gallbladder Problems
- Celiac Disease or Sprue
- Gastrointestinal Bleeding
- Irritable Bowel Syndrome
- Yellow Skin and / or Jaundice
- Stomach Ulcer or Duodenal Ulcer
- Esophageal Stricture or Narrowing
- Helicobacter Pylori Infection (H. Pylori)
- Anal Fissure
- Colon Polyps
- Diverticulosis
- Crohn's Disease
- Colitis / Ulcerative
- Intestinal Infection
- Bowel Obstruction
- Acid Reflux / GERD
- Liver Failure / Cirrhosis
- Hemorrhoids
- Barrett's Esophagus
- Alcohol Abuse
- Pancreatitis
- Diverticulitis
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Other (please specify): _____
- **NONE**

**Non-Gastrointestinal Conditions**

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

**Cancer**

- Mouth / Throat
- Esophagus
- Stomach
- Colon or Rectum
- Blood (e.g., Leukemia)
- Prostate
- Lung(s)
- Breast(s)
- Uterus
- Ovary(ies)
- Skin
- Pancreas
- 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** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **Sibling** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **Offspring** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **Aunt / Uncle** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

Have any of your blood relatives had **Colon Polyps?**

| | Yes | No | Age relative developed condition, if known: 20's | 30's | 40's | 50's | 60's | 70's | 80+ |
|---|---|---|---|---|---|---|---|---|---|
| **Grandparent** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **Parent** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **Sibling** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **Offspring** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **Aunt / Uncle** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

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

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

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Please answer every question.

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## 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** never ○ current (every day) ○

- **How would you describe your cigarette smoking?** in the past ○ current (some days) ○
- **How many packs per day do you (or did you) smoke?** <1 ○ 1 - 2 ○ >2 ○
- **How many years have you (or did you) smoke?** 5 or less ○ 6 - 10 ○ >10 ○
- **Do you use other tobacco products?** never ○ in the past ○ currently ○
- **Are you exposed to passive (second hand) smoke?** yes, outdoors only ○ yes ○ no ○

**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 ○ currently ○ in the past ○ prefer to discuss with doctor ○

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

**Have you ever had a blood transfusion?** yes ○ no ○

**Tattoo(s)?** yes ○ no ○

**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".**

**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**

**Has your stool tested positive for blood?** Yes ○ No ○

**Have you ever had x-rays, CT or ultrasound of your abdomen or GI tract?** Yes ○ No ○

**GENERAL**

- ○ Fatigue
- ○ Night Sweats
- ○ Loss of Appetite
- ○ Sleep Disturbance
- ○ Chills / Fever
- ○ Weight Loss
- ○ Weight Gain
- ○ **NONE**

**NEUROLOGICAL**

- ○ Frequent Headaches
- ○ Passing Out
- ○ Convulsions or Seizures
- ○ Alzheimer's / Dementia
- ○ 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
- ○ High Cholesterol or Triglycerides
- ○ **NONE**

**RESPIRATORY**

- ○ Shortness of Breath
- ○ Wheezing
- ○ Chronic Cough
- ○ Coughing up Sputum
- ○ Sleep Apnea
- ○ Chronic or Frequent Hoarseness
- ○ Exposure to Tuberculosis (TB)
- ○ Spitting up Blood
- ○ **NONE**

## CURRENT CONDITIONS (continued)

| | | |
|---|---|---|
| **GENITOURINARY** | | Prostate Problems |
| | Kidney Stones | Painful / Difficult Urination |
| | Frequent Urinary Infections | Frequent Urination |
| | Blood in Urine | Incontinence |
| | Kidney Failure | NONE |
| **ENDOCRINE** | | Diabetes |
| | Thyroid Disease | NONE |
| **FEMALES ONLY** | | Heavy Menstrual Periods |
| | Endometriosis | Are you or could you be pregnant? |
| | Painful Menstrual Periods | NONE |
| **PSYCHOSOCIAL** | Usually Feel Lonely or Depressed | Stress |
| | Anxiety | NONE |
| **SKIN** | Severe Itching | Unusual Mole(s) |
| | Rash | Flushing |
| | Change in Hair or Nails | NONE |
| **BONE & JOINT** | Arthritis | Back Pain |
| | Joint Pain | NONE |
| **BLOOD** | | Enlarged or Painful Lymph Nodes |
| | Easy Bruising | Anemia |
| | Excessive Bleeding | NONE |
| **EYES** | | Glaucoma |
| | Blurred / Double Vision | Eye Disease |
| | Glasses or Contacts | NONE |
| **EARS / NOSE / THROAT** | Nose or Gums Bleeding | Mouth Sores |
| | Bad Breath or Bad Taste in Mouth | NONE |

**Do you have an advance directive?** yes ◯ no ◯

**If yes, do we have a copy?** yes ◯ no ◯

## SURGERIES

**Please mark all surgeries that you have had:**

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

## OTHER PAST OPERATIONS OR MEDICAL PROBLEMS

**If not already covered in this questionnaire.**

_____

_____

_____

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## PROCEDURES

**Please indicate if you have had any of the following.**

| YES | NO | | Date (approximate) & findings: |
|---|---|---|---|
| ◯ | ◯ | Colonoscopy | |
| ◯ | ◯ | Upper Endoscopy | |
| ◯ | ◯ | Flexible Sigmoidoscopy | |

## 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, passed out, shock, shortness of breath, etc.)**.**

_____

_____

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

_____

_____

## FIBER SUPPLEMENTS

**Are you taking any fiber supplements?** yes ◯ no ◯

(Please list): _____

## MEDICATIONS

**Please list all medications you are currently taking.**

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

| Name of Medication | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
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| | | |
| | | |
| | | |

| Name of Medication | Dosage | Frequency |
|---|---|---|
| | | |
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| | | |

## REASON FOR VISIT

_____

_____

**Occupation:** _____ **Referring MD:** _____

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