Print in Color or Grayscale Only
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Adult 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.
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
- ◯ 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
- ◯ Colon Polyps
- ◯ Crohn's Disease
- ◯ Colitis / Ulcerative
- ◯ Bowel Obstruction
- ◯ Diverticulosis
- ◯ Diverticulitis
- ◯ Hemorrhoids
- ◯ Anal Fissure
- ◯ Eating Disorders
- ◯ Jaundice (Yellow Skin)
- ◯ Liver Failure / Cirrhosis
- ◯ Alcohol Abuse
- ◯ Hepatitis A
- ◯ Hepatitis B
- ◯ 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**

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

Has 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	◯	◯		◯	◯	◯	◯	◯	◯	◯

FAMILY HISTORY continued on next page...

FAMILY HISTORY continued...

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

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
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? (e.g., anal sex, homosexual activity, multiple sex partners, etc.)		never		currently
		in the past		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".

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 an x-ray, CT or ultrasound of your abdomen or GI tract?	Yes	No

CURRENT CONDITIONS continued on next page...

CURRENT CONDITIONS continued...

GENERAL	Fatigue	Chills / Fever
	Night Sweats	Weight Loss
	Appetite Loss	Weight Gain
	Sleep Disturbance	NONE
NEUROLOGICAL	Frequent Headaches	Dizziness
	Fainting	
	Convulsions or Seizures	NONE
CARDIOVASCULAR	Chest Pain or Pressure (after eating or when upset)	Leg Swelling
	Chest Pain or Pressure with Exertion (angina)	
	Irregular Heart Rate / Palpitations	NONE
RESPIRATORY	Shortness of Breath	Chronic or Frequent Hoarseness
	Wheezing	Tuberculosis Exposure (TB)
	Chronic Cough	Spitting up Blood
	Coughing up Sputum	NONE
GENITOURINARY	Kidney Stones	Painful / Difficult Urination
	Frequent Urinary Infections	Frequent Urination
	Blood in Urine	Incontinence
	Prostate Problems	NONE
ENDOCRINE	Cold Intolerance	
	Heat Intolerance	NONE
FEMALES ONLY	Heavy Menstrual Periods	Painful Menstrual Periods
	Are you or could you be pregnant?	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	Easy Bruising	Enlarged or Painful Lymph Nodes
	Excessive Bleeding	NONE
EYES	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
- 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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Please answer every question.

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OTHER PAST MEDICAL PROBLEMS

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

_____

_____

_____

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.)

Name of Medication	Dosage	Frequency

Name of Medication	Dosage	Frequency

Occupation: _____

Referring MD: _____

Last Menstrual Period: _____

Primary MD / OB-GYN: _____