Do not write, stamp, punch holes or affix a sticker in this area.

♠ Direction of Feed **♠ Patient Medical History**

STAFF: Handwritten items must be manually entered. Do not fold this form.

To reproduce, follow the printing instructions.

Please answer every question

PLEASE PRINT PATIENT'S LAST NAME

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

PLEASE PRINT PATIENT'S FIRST NAME						PATIENT'S DATE OF BIRTH				
						Month	Dav	Y	l l ear	
							l i' l		i i	

Please complete this history form. This will allow us to serve yo

The information contained h	piete this history John. Thi nerein is strictly confidentia			re us to do so.			
PATIENT MEDICAL HISTORY	Mark all conditions that	you have had. If	you have had none in a cat	egory, mark NONE.			
GASTROINTESTINAL CONDITIONS							
Celiac Disease or Sprue Gastrointestinal Bleeding Irritable Bowel Syndrome (IBS) Yellow Skin / Jaundice Stomach Ulcer / Duodenal Ulcer Esophageal Stricture / Narrowing Helicobacter Pylori (H. pylori)	Intestinal Infecti Bowel Obstructi Acid Reflux / GE Liver Failure / Ci Barrett's Esopha Chronic Constipa Gallbladder Prot	on RD rrhosis gus ation	Anal Fissure Colon Polyps Diverticulitis Diverticulosis Crohn's Disease Ulcerative Colitis Alcohol Abuse	Hiatal Hernia Pancreatitis Hemorrhoids Hepatitis A Hepatitis B Hepatitis C Other NONE			
NON-GASTROINTESTINAL CONDITION Congestive Heart Failure Hardening of the Arteries Heart Disease / Heart Attack Treatment with Blood Thinner Abnormal Heartbeat / Palpitations Antibiotic Treatment in Past 2 Mon	HIV Exposure Seizure Disorder Multiple Scleros Bleeding Disorde High Blood Press	is (MS) er sure	Kidney Disease Diabetes Blood Clots HIV Positive Fibromyalgia Thyroid Disease	Lupus Stroke Anemia Arthritis Asthma			
CANCER		<u> </u>	y. o.u Diocuse				
Esophageal Blood Mouth / Throat Ovar Colon / Rectal Stom		Prostate Pancreatic Skin	Lungs Uterine Breast	Liver Other NONE			
FAMILY HISTORY	Fill in the oval if a relative	has had one of t	he following.				
Family History Unknown Adopted Other Family History Not Listed NONE							
Prostate Cancer Cirrh Stomach Cancer Celia Bleeding Disorder Brea Hemochromatosis Alcol	ble Bowel Syndrome osis c Disease st Cancer hol Abuse ine Cancer	Ovarian Cancer Crohn's Disease Ulcerative Colitis Cancer, Other Blood Clots Pancreatitis	Liver Failure Liver Cancer Heart Attack Hypertension Ulcer Disease Tuberculosis (TB)	Stroke Diabetes Sickle Cell Gallstones Hepatitis B Hepatitis C			
Yes No 20's 30's	had Colorectal Cancer? re developed condition, if known a 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 Daughter					
Son Other		Son Other					

Patient Medical History

Please answer every question

STAFF: Handwritten items must be manually entered.

Do not fold this form.

To reproduce, follow the printing instructions.

CURRENTLY ACTIVE SYMPTOMS, TESTS & OTHER CONDITIONS Mark all that apply. If you have no symptoms in a category, mark NONE. Forestand								
HEAD, EARS, EYES, wear glasses glaucoma siepe apinea NONE NOSE & THROAT wear contacts heardsethe headache heart stent swelling of hands or feet fairting / blacking out NONE CARDIOVASCULAR chest pain elevated blood pressure fairting / blacking out NONE GENITOURINARY blood in urine painful urination urinary stream pelvic pain 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 MUSCULOSKELETAL dizziness loss of consciousness seizures Cold intolerance excessive turination NONE ENDOCRINE backache joint stiffness physical disability NONE SKIN itching cases none MUSCULOSKELETAL backache joint stiffness physical disability NONE SKIN itching cases none MUSCULOSKELETAL backache difficulty breathing wheeting wheeting MUSCULOSKELETAL suicidal thoughts depression anxiety NONE MUSCULOSKEL								
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BLOOD				<u> </u>				
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Patient Medical History

STAFF: Handwritten items must be manually entered. Do not fold this form.

To reproduce, follow the printing instructions. Please answer every question Do not fold this form. PERSONAL AND SOCIAL HISTORY **Patient Name: ALCOHOL USE** Do you consume alcohol? in the past never currently Average number of drinks per week (now or in past)? 7 or less 8-14 (15 or more **TOBACCO USE** never (currently (every day) How would you describe your cigarette smoking? in the past (currently (some days) How many packs per day do you (or did you) smoke? less than 1 more than 2 1-2 How many years have you (or did you) smoke? 5 or less 6-10 more than 10 Do you use other tobacco products? currently never (in the past **CAFFEINE USE** occasional How many caffeinated beverages do you consume per day? none 🔘 more than 5 3-5 **OTHER** in the past IV drug use or other recreational drug use? never currently Have you engaged in high risk behavior for sexually in the past transmitted diseases (anal sex, unprotected sex, multiple partners)? currently Have you ever had a blood transfusion? yes no Have you had any recent foreign travel? yes no Do you have any body piercings? no yes Do you have any tattoos? no yes Do you live alone? yes no ALLERGIES Please mark any of these allergies you have: Contrast or Iodine Allergy I HAVE NO KNOWN MEDICATION ALLERGIES Latex Rubber Allergy Anaphylactic or Other Reaction to Anesthesia **MEDICATION ALLERGIES** Please list all 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.) Reaction Reaction Medication or Injection Medication or Injection PRESCRIPTION MEDICATIONS Please list all prescription medications you are currently taking. (Alternatively, bring in an accurate list to your appointment.) I AM NOT CURRENTLY TAKING ANY MEDICATIONS Name of Medication Dosage Frequency Name of Medication Dosage Frequency OVER-THE-COUNTER MEDICATIONS Please list all over-the-counter medications you are currently taking. (e.g., aspirin, Motrin, Tagamet-HB, vitamins, herbs, etc.) Name of Medication Dosage Name of Medication Frequency Dosage Frequency

PREFERRED PHARMACY

REFERRING DOCTOR

PRIMARY DOCTOR