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Direction of Feed

Patient Medical History

Please answer every question

STAFF: *Handwritten items must be manually entered.*

Do not fold this form.

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

Please complete this history form. This will allow us to serve your health needs.
The information contained herein is strictly confidential and will not be released unless you authorize us to do so.

PATIENT MEDICAL HISTORY

Mark all conditions that you have had. If you have had none in a category, 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 Infection
- Bowel Obstruction
- Acid Reflux / GERD
- Liver Failure / Cirrhosis
- Barrett's Esophagus
- Chronic Constipation
- Gallbladder Problems
- 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 CONDITIONS

- Congestive Heart Failure
- Hardening of the Arteries
- Heart Disease / Heart Attack
- Treatment with Blood Thinner
- Abnormal Heartbeat / Palpitations
- Antibiotic Treatment in Past 2 Months
- HIV Exposure
- Seizure Disorder
- Multiple Sclerosis (MS)
- Bleeding Disorder
- High Blood Pressure
- Emphysema / COPD
- Kidney Disease
- Diabetes
- Blood Clots
- HIV Positive
- Fibromyalgia
- Thyroid Disease
- Lupus
- Stroke
- Anemia
- Arthritis
- Asthma
- NONE

CANCER

- Esophageal
- Mouth / Throat
- Colon / Rectal
- Blood (e.g., Leukemia)
- Ovarian
- Stomach
- Prostate
- Pancreatic
- Skin
- Lungs
- Uterine
- Breast
- Liver
- **Other**
- NONE

FAMILY HISTORY

Fill in the oval if a relative has had one of the following.

- **Family History Unknown**
- **Adopted**
- **Other Family History Not Listed**
- **NONE**

- Mental Illness
- Prostate Cancer
- Stomach Cancer
- Bleeding Disorder
- Hemochromatosis
- Autoimmune Hepatitis
- Irritable Bowel Syndrome
- Cirrhosis
- Celiac Disease
- Breast Cancer
- Alcohol Abuse
- Uterine 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

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+
Mother									
Father									
Sister									
Brother									
Daughter									
Son									
Other									

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+
Mother									
Father									
Sister									
Brother									
Daughter									
Son									
Other									

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Patient Medical History

Please answer every question

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CURRENTLY ACTIVE SYMPTOMS, TESTS & OTHER CONDITIONS

Mark all that apply. If you have no symptoms in a category, mark NONE.

Patient Name: _____

GENERAL	night sweats ◯	fever ◯	unintentional weight ◯	
	tiredness ◯	lack of appetite ◯	loss (over 10 lbs) ◯	**NONE** ◯
HEAD, EARS, EYES, NOSE & THROAT			headache ◯	
	wear glasses ◯	glaucoma ◯	sleep apnea ◯	
	wear contacts ◯	hoarseness ◯	decreased hearing ◯	**NONE** ◯
CARDIOVASCULAR	heart stent ◯	swelling of hands or feet ◯	leg cramps ◯	
	chest pain ◯	elevated blood pressure ◯	fainting / blacking out ◯	**NONE** ◯
GENITOURINARY		change in urinary stream ◯	pelvic pain ◯	
	blood in urine ◯	painful urination ◯	urinary frequency ◯	**NONE** ◯
NEUROLOGICAL	dizziness ◯	loss of consciousness ◯	seizures ◯	
	fainting ◯	weakness in extremities ◯	difficult speech ◯	**NONE** ◯
ENDOCRINE		cold intolerance ◯	excessive thirst ◯	
		heat intolerance ◯	excessive urination ◯	**NONE** ◯
MUSCULOSKELETAL	backache ◯	joint stiffness ◯	physical disability ◯	**NONE** ◯
SKIN		itching ◯	rash ◯	**NONE** ◯
RESPIRATORY	chronic cough ◯	difficulty breathing ◯	wheezing ◯	**NONE** ◯
PSYCHIATRIC	suicidal thoughts ◯	depression ◯	anxiety ◯	**NONE** ◯
BLOOD			easy bruising ◯	**NONE** ◯
BREAST		breast mass ◯	breast pain ◯	**NONE** ◯
GASTROINTESTINAL			constipation ◯	heartburn ◯
nausea ◯	food / milk intolerance ◯	painful swallowing ◯	vomiting blood ◯	belching ◯
diarrhea ◯	get full quickly at meals ◯	difficulty swallowing ◯	abdominal pain ◯	black stool ◯
bloating ◯	change in bowel habits ◯	stool incontinence ◯	blood in stool ◯	laxative use ◯
vomiting ◯	painful bowel movement ◯	abdominal swelling ◯	gas / flatulence ◯	**NONE** ◯

Has your stool tested positive for blood in the past 6 months? no ◯ yes ◯

Have you had any of these procedures?

NO	YES			
◯	◯	**Colonoscopy**	Date: _____	Location: _____
◯	◯	**Flexible Sigmoidoscopy**	Date: _____	Location: _____
◯	◯	**Upper Endoscopy**	Date: _____	Location: _____
◯	◯	**ERCP** (endoscopic retrograde cholangiopancreatography)	Date: _____	Location: _____
◯	◯	**EUS** (endoscopic ultrasound)	Date: _____	Location: _____
◯	◯	**CT scan of abdomen or GI tract** (past 6 months)	Date: _____	Location: _____
◯	◯	**Ultrasound of abdomen or GI tract** (past 6 months)	Date: _____	Location: _____
◯	◯	**Mammogram**	Date: _____	Location: _____
◯	◯	**Pap Smear**	Date: _____	Location: _____
◯	◯	**Recent Laboratory Testing**	Date: _____	Location: _____

SURGERIES

Please mark all surgeries you have had. Include the date.

◯ **I HAVE HAD NO SURGERIES**

◯ Gallbladder Removal	Date: _____	◯ Hernia Surgery	Date: _____
◯ Lysis of Adhesions	Date: _____	◯ Shoulder Surgery	Date: _____
◯ Pacemaker Placement	Date: _____	◯ Weight Loss Surgery	Date: _____
◯ Aortic Aneurysm Repair	Date: _____	◯ Hysterectomy	Date: _____
◯ Coronary Artery Bypass Graft	Date: _____	◯ Appendectomy	Date: _____
◯ Automatic Cardiac Defibrillator	Date: _____	◯ Colon Resection	Date: _____
◯ Heart Valve Replacement	Date: _____	◯ Kidney Transplant	Date: _____
◯ Liver Transplant	Date: _____	◯ Back Surgery	Date: _____
◯ Hip Replacement	Date: _____	◯ Brain Surgery	Date: _____
◯ Gastric Resection	Date: _____	◯ Stomach Ulcer	Date: _____
◯ Knee Replacement	Date: _____	◯ TURP	Date: _____
◯ Breast Augmentation	Date: _____	◯ **Other**	Date: _____

OTHER PAST OPERATIONS OR MEDICAL PROBLEMS (Not noted elsewhere in this form.)

_____

_____

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Patient Medical History

Please answer every question

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PERSONAL AND SOCIAL HISTORY

Patient Name: _____

ALCOHOL USE

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

CAFFEINE USE

		occasional ◯	1-2 ◯
How many caffeinated beverages do you consume per day?	none ◯	3-5 ◯	more than 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)**?**	never ◯	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?	yes ◯	no ◯
Do you have any tattoos?	yes ◯	no ◯
Do you live alone?	yes ◯	no ◯

ALLERGIES

Please mark any of these allergies you have:

◯ **I HAVE NO KNOWN MEDICATION ALLERGIES**

◯ Contrast or Iodine Allergy
◯ 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.)

Medication or Injection	Reaction

Medication or Injection	Reaction

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	Frequency

Name of Medication	Dosage	Frequency

PREFERRED PHARMACY

_____

REFERRING DOCTOR

_____

PRIMARY DOCTOR

_____