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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 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+
Father									
Mother									
Brother									
Sister									
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+
Father									
Mother									
Brother									
Sister									
Other									

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**

For technical support, please contact PatientLink at ***Support@MyPatientLink.com.***

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Patient Medical History

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	C-Section	Pacemaker
Adhesions	Esophageal	Prostate
Aortic Aneurysm	Gallbladder	Stomach
Appendix Removal	Heart Bypass	Tonsils
Automatic Defibrillator	Heart Valve	Transplant(s)
Back / Spinal	Hemorrhoids	Tubal Ligation
Bariatric	Hernia / Groin	Ulcer(s)
Brain	Hysterectomy	Other Implanted Device(s)
Breast	Joint Replacement(s)	Other (please specify):
Colon	Joint Surgery(ies)	
Coronary Stent(s)	Laparoscopy	

OTHER PAST OPERATIONS OR MEDICAL PROBLEMS

If not already covered in this questionnaire.

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Patient Medical History

Please answer every question

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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

Name of Medication	Dosage	Frequency

REASON FOR VISIT

_____

_____

Occupation: _____

Referring MD: _____

Primary MD: _____