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

Patient Medical History

Please answer every question.

STAFF: Handwritten responses 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

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

Please mark all conditions YOU have had:

GASTROINTESTINAL CONDITIONS

- Celiac Disease or Sprue
- Gastrointestinal Bleeding
- Irritable Bowel Syndrome (IBS)
- Yellow Skin / Jaundice
- Stomach Ulcer or Duodenal Ulcer
- Esophageal Stricture or Narrowing
- Helicobacter Pylori (H. pylori)
- Bowel Obstruction
- Liver Problems
- Acid Reflux / GERD
- Liver Failure / Cirrhosis
- Barrett's Esophagus
- Chronic Constipation
- Gallbladder Problems
- Stomach Cancer
- Anal Fissure
- Colon Polyps
- Diverticulitis
- Diverticulosis
- Crohn's Disease
- Ulcerative Colitis
- Alcohol Abuse
- Colon Cancer
- Rectal Cancer
- Hiatal Hernia
- Pancreatitis
- Hemorrhoids
- Hepatitis A
- Hepatitis B
- Hepatitis C

NON-GASTROINTESTINAL CONDITIONS

- Congestive Heart Failure
- Heart Disease / Heart Attack
- Seizure Disorder
- Bleeding Disorder
- High Blood Pressure
- Prostate Problems
- Emphysema or COPD
- Heart Valve Disease
- HIV Positive
- Thyroid Disease
- Stroke
- Asthma
- Kidney Stones
- Heart Murmur
- Anxiety Disorder
- Anemia
- Depression
- Diabetes
- Renal Failure
- Arthritis

OTHER CONDITIONS

If you have any additional past medical history, please write on the lines below.
If you have no medical history, mark "NO SIGNIFICANT PAST MEDICAL HISTORY."

- NO SIGNIFICANT PAST MEDICAL HISTORY

FAMILY MEDICAL HISTORY

- FAMILY HISTORY UNKNOWN
- ADOPTED

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									

Fill in the oval if a relative (parent, grandparent, sibling, children, aunt or uncle) **has had any of the following:**

- Stroke
- Cirrhosis
- Stomach Cancer
- Hemophilia
- Breast Cancer
- Alcohol Abuse
- Crohn's Disease
- Ulcerative Colitis
- Pancreatitis
- Heart Attack
- Ulcer Disease
- Tuberculosis (TB)
- Diabetes
- Gallstones
- Hepatitis B
- Hepatitis C

If you have any additional family medical history, please write on the lines below.
If you have no family medical history, mark "NO SIGNIFICANT FAMILY MEDICAL HISTORY."

- NO SIGNIFICANT FAMILY MEDICAL HISTORY

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Patient Medical History

Please answer every question.

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CURRENTLY ACTIVE SYMPTOMS & TESTS

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

GENERAL	fever ◯		tiredness ◯	
	lack of appetite ◯		unintentional weight loss (over 10 lbs) ◯	**NONE** ◯
HEAD, EARS, EYES, NOSE & THROAT			glaucoma ◯	
	headache ◯		mouth sores ◯	
	hoarseness ◯		decreased hearing ◯	**NONE** ◯
CARDIOVASCULAR	leg cramps ◯		chest pain ◯	**NONE** ◯
GENITOURINARY			menstrual problems ◯	
	blood in urine ◯		frequent urination ◯	**NONE** ◯
NEUROLOGICAL	dizziness ◯		seizure ◯	**NONE** ◯
MUSCULOSKELETAL	backache ◯		muscle / joint pain ◯	**NONE** ◯
SKIN			rash ◯	**NONE** ◯
RESPIRATORY			shortness of breath ◯	**NONE** ◯
PSYCHIATRIC			depression ◯	**NONE** ◯
BLOOD			easy bruising ◯	**NONE** ◯
GASTROINTESTINAL			nausea ◯	
	diarrhea ◯	change in bowel habits ◯	black stool ◯	
	bloating ◯	get full quickly at meals ◯	blood in stool ◯	
	vomiting ◯	abdominal swelling ◯	gas / flatulence ◯	
	belching ◯	vomiting blood ◯	stool incontinence ◯	
	heartburn ◯	abdominal pain / cramps ◯	food / milk intolerance ◯	
	constipation ◯	painful swallowing ◯	difficulty swallowing ◯	**NONE** ◯

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

Have you had a colonoscopy?

no ◯ yes ◯ Date: _____ Findings: _____

SOCIAL HISTORY

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 ◯
How would you describe your cigarette smoking?		**NEVER** ◯	currently (every day) ◯
		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 smokeless / chewing tobacco?	**NEVER** ◯	in the past ◯	currently ◯
How many caffeinated beverages do you consume per day?		occasional ◯	3-5 ◯
	NONE ◯	1-2 ◯	more than 5 ◯

SURGERIES

Please mark all surgeries you have had:

◯ **I HAVE HAD NO SURGERIES**

◯ Defibrillator ◯ Heart Stent ◯ Pacemaker Placement ◯ Heart Valve Replacement ◯ Reflux Surgery ◯ Gallbladder Removal ◯ Weight Loss Surgery ◯ Appendectomy ◯ Stomach Surgery

Please list all additional surgeries you have had:

_____

_____

_____

_____

ALLERGIES

Please indicate if you are allergic to any of the following:

◯ **NO KNOWN MEDICATION ALLERGIES**

◯ Anaphylactic or Other Reaction to Anesthesia
◯ NSAIDs (e.g., Aspirin, Naproxen, Ibuprofen, Ketoprofen)
◯ Latex Rubber Allergy
◯ Contrast or Iodine Allergy