Patient Medical History

PLEASE PRINT YOUR LAST NAME

PLEASE PRINT YOUR FIRST NAME

PLEASE PRINT YOUR DATE OF BIRTH

Month Day Year

YOUR SOCIAL SECURITY NUMBER

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.

Marking Instructions

- ***Use a #2 Pencil.***
- ***Mark all items that apply to you.***
- ***Fill in the complete oval as shown . . .***

Incorrect Marks

PATIENT MEDICAL HISTORY

Fill in the oval if you have had any of the conditions listed below, or fill in the "NONE" oval.

Gastrointestinal Conditions

- Barrett's Esophagus
- Liver Failure/Cirrhosis
- Celiac Disease or Sprue
- Gastrointestinal Bleeding
- Irritable Bowel Syndrome
- Stomach Ulcer or Duodenal Ulcer
- GERD/Esophagitis/Acid Heartburn
- Esophageal Stricture or Narrowing
- History of Helicobacter Pylori Infection
- Hemorrhoids
- Anal Fissure
- Colon Polyps
- Diverticulosis
- Crohn's Disease
- Colitis/Ulcerative
- Intestinal Infection
- Bowel Obstruction
- Other Liver Disease
- Gallstones
- Pancreatitis
- Diverticulitis
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Autoimmune
- Other
- **NONE**

Non-Gastrointestinal Conditions

- Bleeding Disorder
- Multiple Sclerosis
- High Blood Pressure
- Emphysema or COPD
- Congestive Heart Failure
- Hardening of the Arteries
- Atrial Fibrillation/Arrhythmia
- Treatment with Blood Thinner
- Coronary Artery Disease/Heart Attack
- Antibiotic Treatment Within Past 2 Months
- Lupus
- Stroke
- Asthma
- Anemia
- Diabetes
- Blood Clots
- HIV Positive
- Fibromyalgia
- Seizure Disorder
- **NONE**

Cancer

- Mouth/Throat
- Esophagus
- Stomach
- Colon or Rectum
- Blood (e.g. leukemia)
- Prostate
- Lungs
- Breast
- Uterus
- Ovaries
- Skin
- Pancreas
- Other
- **NONE**

FAMILY HISTORY

Have any of your blood relatives had colorectal cancer? Yes No

If yes, at what age did your family member have colorectal cancer?

	20's	30's	40's	50's	60's	70's	80+
Grandparent							
Parent							
Sibling							
Offspring							
Aunt/Uncle							

Other family history: Fill in the oval if a relative — parent, grandparent, sibling, offspring, aunt or uncle — has had one of the following.

- Breast Cancer
- Ovarian Cancer
- Uterine Cancer
- Stomach Cancer
- Liver Cancer
- Autoimmune Hepatitis
- Irritable Bowel Syndrome
- Hepatitis B
- Hepatitis C
- Celiac Disease
- Crohn's Disease
- Ulcerative Colitis
- Bleeding Disorder
- Hemachromatosis
- Gallstones
- Pancreatitis
- Liver Failure
- Blood Clots
- **NONE**

PERSONAL AND SOCIAL HISTORY

Question	Answer options
Occupation:	______________________
Marital Status:	⬭ married ⬭ single ⬭ divorced ⬭ widowed
Do you live alone?	⬭ yes ⬭ no
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
Have you tried to cut down on your alcohol consumption?	⬭ yes ⬭ no
Does criticism of your alcohol use annoy you?	⬭ yes ⬭ no
Do you feel guilty about your alcohol use?	⬭ yes ⬭ no
Do you ever have a morning “eye opener”?	⬭ yes ⬭ no
How would you describe your cigarette smoking?	⬭ never ⬭ in the past ⬭ currently
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 ⬭ more than 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
Recreational drug use?	⬭ never ⬭ in the past ⬭ currently ⬭ prefer to discuss with doctor
Have you engaged in high risk sexual behavior?	⬭ never ⬭ in the past ⬭ currently ⬭ prefer to discuss with doctor

Symptoms & Other Conditions

*(**Mark all that apply** - if no symptoms, please mark **“none”**)*

GASTROINTESTINAL

- ⬭ heartburn
- ⬭ difficulty swallowing
- ⬭ painful swallowing
- ⬭ abdominal pain
- ⬭ nausea
- ⬭ vomiting
- ⬭ get full quickly at meals
- ⬭ abdominal distention
- ⬭ gas/flatulence
- ⬭ bloating
- ⬭ belching
- ⬭ irregular bowel habits
- ⬭ diarrhea
- ⬭ constipation
- ⬭ incontinence of stool
- ⬭ black stools
- ⬭ fresh blood in stools
- ⬭ vomiting blood
- ⬭ jaundice
- ⬭ **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

Please mark oval if you have had any of these procedures.

- ⬭ Colonoscopy
- ⬭ Flexible Sigmoidoscopy
- ⬭ Gastroscopy
- ⬭ ERCP (Endoscopy of bile ducts or pancreas)

Symptoms & Other Conditions - (Cont.) ***(Mark all that apply -** if no symptoms, please mark **"none")***

GENERAL	fatigue ○ night sweats ○ loss of appetite ○ feeling of excessive cold or warmth ○ history of IV drug use ○ history of IV blood transfusion ○	chills/fever ○ weight loss ○ weight gain ○ sleep disturbance ○ **none** ○
NEUROLOGICAL	frequent headaches ○ recent passing out ○ convulsions or seizures ○	history of stroke ○ recent dizziness ○ **none** ○
CARDIOVASCULAR	history of heart murmur ○ history of rheumatic fever ○ chest pain or chest pressure after eating or when upset ○ chest pain or pressure with exertion (angina) ○ irregular heart rate, palpitations ○ coronary stents ○	leg swelling ○ pacemaker ○ automatic defibrillator ○ high cholesterol or triglycerides ○ **none** ○
RESPIRATORY	shortness of breath ○ wheezing ○ chronic cough ○ cough up sputum ○	chronic or frequent hoarseness ○ exposure to tuberculosis ○ lung cancer ○ **none** ○
GENITOURINARY	kidney stones ○ frequent urinary infections ○ blood in urine ○ kidney failure ○	difficulty urinating ○ incontinence ○ **none** ○
ENDOCRINE	thyroid disease ○ diabetes ○	**none** ○
FEMALE	endometriosis ○ painful menstrual periods ○ heavy menstrual periods ○	Are you or could you be pregnant? ○ **none** ○
PSYCHOSOCIAL	history of mental illness ○ history of depression ○ history of physical or sexual abuse ○ history of eating disorders ○	usually feel lonely or depressed ○ anxiety ○ stress ○ **none** ○
SKIN	severe itching ○ rash ○	flushing ○ **none** ○
BONE & JOINT	arthritis ○ joint pain ○	back pain ○ **none** ○
BLOOD	easy bruising ○ excessive bleeding ○ enlarging or painful lymph nodes ○	anemia ○ **none** ○

SURGERIES

Please mark all surgeries that you have had.

- ⬭ Adhesion
- ⬭ Aortic Aneurysm
- ⬭ Appendix Removal
- ⬭ Back/Spinal
- ⬭ Brain
- ⬭ Colon
- ⬭ Esophagus
- ⬭ Gallbladder
- ⬭ Heart Bypass
- ⬭ Heart Valve
- ⬭ Joint Replacement
- ⬭ Prostate
- ⬭ Stomach
- ⬭ Transplant
- ⬭ Ulcer
- ⬭ Uterine/Ovarian
- ⬭ Weight Loss

ALLERGIES

- ⬭ Medication
- ⬭ Latex/Rubber
- ⬭ Anaphylactic or other reaction to anesthesia
- ⬭ Food

FIBER SUPPLEMENTS

Are you taking any fiber supplements?

⬭ Yes ⬭ No

List: ____________________________________

MEDICATION ALLERGIES

Please list the medications or injections that have given you bad reactions. If possible, include your reactions (hives, welts, rash, itching, headaches, nausea, diarrhea, passed out, shock, shortness of breath).

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____

OTHER PAST OPERATIONS OR MEDICAL PROBLEMS

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What prescription medications are you taking at this time?

Name of Medicine	Dosage	# per day

What over the counter medications are you taking? (e.g. aspirin, Motrin, Tagament-HB, Vitamins)

Name of Medicine	Dosage	# per day

REASON FOR VISIT

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Referring MD ____________________________________

Primary MD ____________________________________