Name: _____ Account #: _____

Height: _____ Weight: _____

Reason for today's visit: _____

Past Medical History: Check ☒ all that apply.

☐ Alcoholism	☐ Colon cancer	☐ Diverticular disease	☐ Pancreatitis
☐ Anemia	☐ Colon polyps	☐ GERD (reflux)	☐ Peptic ulcer disease
☐ Arthritis	☐ Congestive heart failure	☐ HIV/AIDS	☐ Prostate cancer
☐ Asthma	☐ COPD (lung disease)	☐ High cholesterol	☐ Seizure disorder
☐ Blood clots (DVT/PE)	☐ Coronary artery disease	☐ Hypertension (High BP)	☐ Thyroid disease
☐ Breast cancer	☐ Heart attack (MI)	☐ Irritable bowel syndrome	☐ Ulcerative Colitis
☐ Chronic renal failure	☐ Crohn's disease	☐ Kidney stones	☐ _____
☐ Chronic renal insufficiency	☐ Stroke	☐ Liver disease/hepatitis	☐ _____
☐ Cirrhosis	☐ Diabetes	☐ Obesity	☐ _____

Past Surgical History: When was your last colonoscopy / flex sig? _____ Result? _____

Type of Surgery	Year

Type of Surgery	Year

Current Medications: Do you take any blood thinners? ☐ Yes ☐ No _____

Name of Medication	Dose(mg)	Times per day

Name of Medication	Dose(mg)	Times per day

Allergies: Are you allergic to latex? ☐ Yes ☐ No

Name	Reaction

Name	Reaction

Tobacco: ☐Current ☐Former ☐Never **Type:** ☐Cigarette ☐Cigar ☐Chewing ☐Snuff ☐Pipe **Packs per day:** ____ **Years used:** ____

Ever tried to quit? ☐Yes ☐No **Year Quit:** _____

Alcohol: ☐No ☐Yes ☐Formerly **Type:** ☐Beer ☐Wine ☐Liquor **Frequency:** ☐Daily ☐Weekly ☐Occasionally ☐Rarely **Amount:** ____

Street drugs: Type: _____ **Frequency:** _____ **Last use:** _____

Caffeine: ☐No ☐Yes **Type:** _____ **How much?** _____

Employer: _____ **Occupation:** _____

Status: ☐Married ☐Single ☐Divorced ☐Widow/er ☐Partner **Children:** Number of sons: _____ Number of daughters: _____

Name: _____ Account #: _____

Family History: Please list medical problems of your close family members along with cause and age of death.

	Age		Medical Problems	Cause of death
	Alive	@Death		
Mother				
Father				
Brother/Sister (circle one)				
Brother/Sister (circle one)				
Brother/Sister (circle one)				
Brother/Sister (circle one)				
Brother/Sister (circle one)				

Do you have other family members with a history of colorectal, gynecologic, or breast cancer? _____

Symptoms: Check Yes or No for any symptoms you currently have or have had in the past 6 months.

Constitutional

No	Yes	
☐	☐	Chills
☐	☐	Fever
☐	☐	Malaise
☐	☐	Weight Loss

Heent

No	Yes	
☐	☐	Double vision
☐	☐	Ear infections
☐	☐	Eye pain
☐	☐	Nasal congestion
☐	☐	Sinus infection
☐	☐	Sore throat

Respiratory

No	Yes	
☐	☐	Shortness of breath
☐	☐	Frequent cough
☐	☐	Wheezing
☐	☐	Cough up blood

Cardiovascular

No	Yes	
☐	☐	Chest pain
☐	☐	Ankle swelling
☐	☐	Palpitations

Gastrointestinal

No	Yes	
☐	☐	Abdominal pain
☐	☐	Change in bowel habits
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Difficulty swallowing
☐	☐	Heartburn
☐	☐	Vomiting blood
☐	☐	Blood in stool
☐	☐	Loss of appetite
☐	☐	Dark/black stool
☐	☐	Nausea
☐	☐	Reflux
☐	☐	Vomiting

Genitourinary

No	Yes	
☐	☐	Painful urination
☐	☐	Blood in urine
☐	☐	Frequent urination
☐	☐	Urinary incontinence
☐	☐	Urinary retention

Reproductive

No	Yes	
☐	☐	Penile/vaginal discharge
☐	☐	Sexual dysfunction

Metabolic / Endocrine

No	Yes	
☐	☐	Cold intolerance
☐	☐	Excessive thirst
☐	☐	Heat intolerance

Neurological

No	Yes	
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Numbness
☐	☐	Tremors
☐	☐	Vertigo

Psychiatric

No	Yes	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Increased stress

Integumentary

No	Yes	
☐	☐	Contact allergy
☐	☐	Hives
☐	☐	Itching
☐	☐	Rash

Musculoskeletal

No	Yes	
☐	☐	Back pain
☐	☐	Muscle pain
☐	☐	Joint pain

Hematologic/Lymphatic

No	Yes	
☐	☐	Easy bleeding
☐	☐	Easy bruising
☐	☐	Enlarged lymph nodes

Immunologic

No	Yes	
☐	☐	Asthma
☐	☐	Chemicals in work place
☐	☐	Food allergies
☐	☐	Immunosuppression
☐	☐	Seasonal allergies

To the best of my knowledge, the above information is accurate and complete. I understand that it is my responsibility to inform my doctor of any health changes.

Signature: _____ **Date:** _____ **Time:** _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

Reviewed by: _____ **Date:** _____ **Time:** _____