PATIENT HISTORY

PATIENT NAME: _____ ACCT NO. _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____

What is the reason you are seeing the physician today?

_____

MEDICAL PROBLEMS: (Please mark all that apply)

☐ Cardiac Stent / Bypass ☐ Crohn's Disease ☐ Cancer _____
☐ Pacemaker ☐ Ulcerative Colitis ☐ Chemotherapy/Radiation
☐ Defibrillator ☐ Colon Polyps/ Colon Cancer ☐ Sleep Apnea
☐ Heart Failure ☐ Diverticulitis ☐ Diabetes
☐ Heart Attack ☐ Ulcers ☐ Kidney Disease
☐ Coronary Artery Disease ☐ Liver Disease/Hepatitis ☐ Lung Disease
☐ Stroke / TIA ☐ Gallstones ☐ Pancreatic Disease
☐ High Blood Pressure ☐ Hernia ☐ Thyroid Disease
☐ High Cholesterol ☐ Bleeding Tendency ☐ Other

_____

PAST SURGERIES:

☐ Abdominal ☐ Rectal ☐ Colon resection ☐ Colostomy ☐ Cholecystectomy ☐ Appendectomy

☐ Other_____

Have you ever had a Colonoscopy? ☐ No ☐ Yes
If so, when/where_____
Have you ever had an Upper Endoscopy? ☐ No ☐ Yes
If so, when/where_____

<u>Family History</u>: (Please mark all that apply)

☐ **COLON CANCER OR POLYPS** ☐ Pancreatic Cancer ☐ Esophageal Cancer
☐ Celiac Disease ☐ Inflammatory Bowel Disorders (Crohn's or Ulcerative Colitis)

Social History: (Please mark all that apply)

Tobacco use: ☐never ☐past ☐current ☐Amt daily _____
Alcohol use: ☐never ☐past ☐rarely ☐moderate ☐frequent ☐Amt daily_____
Drug use: ☐never ☐past ☐current ☐Type _____

Menstrual History: (women only)

Last Menstrual Cycle:_____ Menopause age:_____
Hysterectomy:_____ Tubal Ligation:_____
Oral contraceptives:_____

- Is there any chance that you are currently pregnant? ☐ No ☐ Yes
- If you become pregnant in the future please discuss your medical conditions and medications with your primary care physician and your OB/GYN.

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____