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: _____