Today's Date: _____ Updates Made: _____

Patient Name:_____ Birth Date: _____ Marital Status: _____

Occupation (if retired, former occupation): _____

Primary Care Provider (Name, City, Phone): _____

Reason for Visit/Complaints/Symptoms: _____ For how long? _____

Have you ever had a colonoscopy? YES NO If yes: when/where?_____

Are you here for a SCREENING colonoscopy? YES NO

Have you done a Fecal Hemoccult or Cologuard test? YES NO If yes: when? _____ Positive or Negative?

Have you had recent x-rays, blood work, other medical tests? YES NO If yes: where? _____

Has your weight changed? NO YES -----> Circle: GAINED or LOST _____ pounds over _____ months

Approximately how much do you weigh now? _____ pounds How tall are you? _____feet, _____inches

DO YOU HAVE or have you ever had ANY OF THE FOLLOWING?

	NO	YES		NO	YES		NO	YES
Bowel Disease			Diabetes			Kidney Disease		
Cancer			Diarrhea			Liver Disease		
Cirrhosis			Heartburn			Lung Disease (Asthma / COPD)		
Colon Polyps			Heart Failure/Attack			Rectal Bleeding		
Constipation			Hiatal Hernia			Ulcer Disease		
Crohn's Disease			High Blood Pressure			Ulcerative Colitis		
CVA/Stroke/Seizure			Inflammatory Bowel			Other: (list) _____		

PAST SURGERIES	**Year Performed**	**PAST SURGERIES**	**Year Performed**

PAST MAJOR ILLNESSES

DO YOU HAVE any condition for which you take antibiotics prior to medical or dental procedures (for example: pacemaker artificial joints, heart murmur, heart valve disorder)? YES NO If YES, please list condition(s):

Please continue on reverse.