*The following information is very important to your health. Please take time to fully and completely fill out this important information.*

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_REFERRED BY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REASON FOR VISIT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Height\_\_\_\_\_\_\_\_\_\_\_\_\_Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Past or Present Medical Problems:**

O None O Colon Cancer O Diverticulitis O Diverticulosis OAnemia

O Crohn’s Dis. O Ulcerative Colitis O Irritable Bowel O Celiac Dis. O Pancreatitis

O Barrett’s Esop. O GERD O Esop. Cancer O Ulcer O Gallstones

O Hepatitis O Liver Disease O Stroke O Osteoporosis O Seasonal allergies

O Arthritis O Diabetes O Hypertension O Lupus O High Cholesterol

O Gout O Sleep Apnea O Breast Cancer O Lung Cancer O Asthma

O COPD O Anxiety O Prostate Cancer O Kidney Disease O Kidney Stones

O Psychiatric Dis. O Depression O Seizure Disorder O Gyn Cancer O HIV/Aids

O Heart Disease O Atrial Fib. O Irreg. heartbeat O Bleeding Disorder/blood transfusion.

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you see a cardiologist, if so whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries/Hospitalization/Procedures:** O None

Have you had a colonoscopy, if so where and when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had an upper endoscopy, EGD, or ERCP, if so where and when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

O Colon Surgery O Gallbladder Surgery O ERCP O Gastric Bypass O Hernia Surgery

O Prostate Surgery O Hysterectomy O C-Section O Appendectomy O Orthopedic Surgery

O Heart Surgery O Heart Stent O Pacemaker O Defibrillator (AICD) Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies:

O None O Demerol/Fentanyl O IV Contrast or Iodine O Penicillin O Sulfa O Latex

O Aspirin O Eggs O Propofol/Diprivan OVersed O Other\_\_\_\_\_\_\_\_

**List of Medications:** Please list your medications, or if you have a written list, please provide it and we will make a copy:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History - Marital Status** **Recreational Drugs** O None

O Single O Married O Separated O I have used IV drugs in the past.

O Divorced O Widowed O Partnered O I currently use recreational drugs.

O Children, Y/N, How many\_\_\_\_ O I have been treated for substance abuse

**Social History -Alcohol** **Social History - Tobacco**

O Never O More than 2 days/week. O I use tobacco products, \_\_\_pack per day.

O Rarely O Less than 2 days/week. O I have never used tobacco products.

O Daily O I quit using alcohol in\_\_\_\_\_\_\_\_ O I quit using tobacco products in \_\_\_\_\_

**Social History - Occupation** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_O Retired

**FAMILY HISTORY:**

Has anyone in your family had a history of either colon cancer or polyps? If so whom?

Has anyone in your family had a history of inflammatory bowel disease, such as ulcerative colitis or Crohn’s disease, esophageal cancer, gastric cancer, pancreatic cancer, liver disease, hepatitis C or B, gynecological or breast cancer? If so, whom and what did they have?

Has anyone in your family had similar problems to yours?

**Review of Systems:**

**Gastrointestinal:** O None Please check or circle all that apply.

O Blood in Stool O Change in Bowel Habits O Nausea O Gas

O Trouble swallowing O Hemorrhoids O Fecal Incontinence O Jaundice

O Heartburn O Milk Intolerance O Black Stools O Vomiting

O Loss of Appetite O Belching O Diarrhea O Painful Bowel Movement O Abdominal pain O Constipation O IBS O Bloating

O Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any other symptoms, please circle and add as needed:**

**Hematologic**: None Anemia / easy bruising / prolonged bleeding \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Genitourinary**: None blood in urine / incontinence / irreg menses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin**: None rash / itching / jaundice \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiovascular**: None chest pain / irregular heartbeat / ankle swelling \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Neurological**: None seizures / dizziness / stroke / paralysis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Endocrine:** None excessive thirst / intolerance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Constitutional**: None weight gain / weight loss / fever \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychiatric**: None depression / memory loss / confusion / anxiety \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eyes**: None change in vision / eye problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ear, nose, throat**: None hoarseness / dry mouth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Musculoskeletal**: None Muscle pain / joint pain / arthritis. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Respiratory:** None wheezing / chronic cough / shortness of breath \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immunologic:** None frequent infections / immune disorders \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list other any major symptoms:**

**The above is true and correct to the best of my belief.**

**Patient's Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**