MEDICAL HISTORY

Name	Date
Chief Complaint/Reason for Visit	Referred By
Height	Weight

MEDICATIONS: List name, dosage/strength, frequency. (Please be sure to list all medications, including aspirin, pain relievers, vitamins, birth control pills, blood thinners, antacids, etc.)

PAST MEDICAL HISTORY: (Please check if applicable and/or circle certain type)

Alcoholism	□	Crohn's	□	High Cholesterol	□
Anemia	□	Depression	□	Hypertension	□
Anxiety	□	Diabetes (Type I, II or Mellitus)	□	Kidney Disease	□
Arthritis	□	Diverticulosis	□	Lung Disease (asthma, emphysema)	□
Black Bloody Stool	□	Endocarditis	□	Pancreatitis	□
Bleeding Disorder	□	Gallstones	□	Rheumatic Fever	□
Cancer _____	□	Heart Disease (angina, heart attack)	□	Spastic Colon	□
Chronic Diarrhea	□	Heart Failure	□	Thyroid Problems	□
Cirrhosis	□	Heartburn	□	Ulcers	□
Colitis	□	Hemorrhoids	□	Valve Replacement	□
Colon Polyps	□	Hepatitis (A, B or C)	□	Yellow Jaundice	□
Constipation	□	Hernia	□	Other:_____	□

Smoking: Yes □ No □ Alcohol: Yes □ No □ Blood Transfusions in Past: Yes □ No □ When? _____
Female Patients Only: Pregnancies: _____ Last Menstrual Period: _____

ALLERGIES: (Include both drug and food allergies – iodine/shellfish)

PAST SURGICAL HISTORY: (Please list all surgeries including month and year done)

PAST ENDOSCOPIC HISTORY: (Please list date, findings and place endoscopy was done)

FAMILY HISTORY: (Please include illnesses, specifically cancers of the colon, stomach, rectum, etc.)

Mother
Father
Brothers/Sisters (how many of each)
Aunts/Uncles - Maternal or Paternal
Sons/Daughters (how many of each)

INFORMATION REVIEWED AND VERIFIED BY PATIENT:

_____ _____
Date and Initials Date and Initials

_____ _____
Date and Initials Date and Initials