

MEDICAL HISTORY

NAME		DATE	
CHIEF COMPLAINT			
HEIGHT	WEIGHT	REFERRED BY	
PAST MEDICAL HISTORY: (PLEASE CHECK IF APPLICABLE)			
ALCOHOLISM <input type="checkbox"/>	COLON POLYPS <input type="checkbox"/>	HERNIA <input type="checkbox"/>	
ARTHRITIS <input type="checkbox"/>	CONSTIPATION <input type="checkbox"/>	HEPATITIS <input type="checkbox"/>	
ASTHMA <input type="checkbox"/>	DIABETES <input type="checkbox"/>	PANCREATITIS <input type="checkbox"/>	
BLACK BLOODY STOOL <input type="checkbox"/>	DIVERTICULOSIS <input type="checkbox"/>	RHEUMATIC FEVER <input type="checkbox"/>	
CANCER <input type="checkbox"/>	ENDOCARDITIS <input type="checkbox"/>	SPASTIC COLON <input type="checkbox"/>	
CHRONIC DIARRHEA <input type="checkbox"/>	GALLSTONES <input type="checkbox"/>	ULCERS <input type="checkbox"/>	
CIRRHOSIS <input type="checkbox"/>	HEARTBURN <input type="checkbox"/>	VALVE REPLACEMENT <input type="checkbox"/>	
COLITIS <input type="checkbox"/>	HEART FAILURE <input type="checkbox"/>	YELLOW JAUNDICE <input type="checkbox"/>	
CROHN'S <input type="checkbox"/>	HEMORRHOIDS <input type="checkbox"/>	OTHERS:	
SMOKING: YES <input type="checkbox"/> NO <input type="checkbox"/>		ALCOHOL: YES <input type="checkbox"/> NO <input type="checkbox"/> BLOOD TRANSFUSIONS IN PAST YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, WHEN	
FOR FEMALE PATIENTS ONLY:		PREGNANCIES	LAST MENSTRUAL PERIOD
PAST SURGICAL HISTORY: (PLEASE LIST ALL SURGERIES)			
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ALLERGIES: (INCLUDE BOTH DRUG AND FOOD ALLERGIES -- IODINE/SHELLFISH)			
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MEDICATIONS: (PLEASE LIST ALL MEDICATIONS: INCLUDE ASPIRIN, MOTRIN, ALLEVE, EXCEDRIN, VITAMINS, TYLENOL, BIRTH CONTROL PILLS, BLOOD THINNERS, COUMADIN, ANTACIDS)			
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FAMILY HISTORY: (PLEASE INCLUDE IN HISTORY ILLNESSES, SPECIFICALLY CANCERS OF THE COLON, STOMACH, RECTUM, ETC.)			
MOTHER			
FATHER			
BROTHERS/SISTERS			
AUNTS/UNCLES			
CHILDREN/OTHERS			

REVIEWED BY DR. _____ DATE _____