

Name: _____ DOB: _____ Date: _____

Chief Complaint (Why are you here?): _____ Referring person: _____

PAST MEDICAL HISTORY: No medical conditions

Common Conditions

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gastroesophageal
Reflux/GERD | <input type="checkbox"/> High blood
pressure/Hypertension |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart attack/MI | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Diabetes | | |
| <input type="checkbox"/> Other(s): | | |

COLONOSCOPY HISTORY: No previous colonoscopy

Past colonoscopies/or flexible sigmoidoscopies (date and finding):

PAST SURGICAL HISTORY: No surgical history

- | | | |
|---|---|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Hernia | <input type="checkbox"/> Laminectomy |
| <input type="checkbox"/> Cardiac bypass | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Pacemaker <input type="checkbox"/> ICD |
| <input type="checkbox"/> Cardiac stent | <input type="checkbox"/> Joint replacement hip | <input type="checkbox"/> Prostatectomy |
| <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Joint replacement knee | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Pregnancy history: # of vaginal deliveries _____ # of C-sections _____ | | |
| <input type="checkbox"/> Other(s): | | |

MEDICATIONS: No current medications

- | | | |
|---|----------------------------------|---------------------------------|
| <input type="checkbox"/> Coumadin | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Plavix |
| <input type="checkbox"/> Other blood thinning medication: | | |

Please list all other medications:

ALLERGIES: No known drug allergies Latex allergy

Please list drug allergies and reactions:

Name: _____ DOB: _____ Date: _____

FAMILY HISTORY: No family history

(Please check appropriate box describe relationship- ie. Parent, sibling, cousin, etc.)

- | | |
|--|---|
| <input type="checkbox"/> Breast cancer _____ | <input type="checkbox"/> Crohn's disease _____ |
| <input type="checkbox"/> Colon cancer _____ | <input type="checkbox"/> Ovarian cancer _____ |
| <input type="checkbox"/> Colon polyps _____ | <input type="checkbox"/> Ulcerative Colitis _____ |
| <input type="checkbox"/> Other: _____ | |

SOCIAL HISTORY:

Alcohol

- | | | |
|---------------------------------|---|-------------------------------|
| <input type="checkbox"/> Never | <input type="checkbox"/> 1-2 drinks/day | <input type="checkbox"/> Quit |
| <input type="checkbox"/> Social | <input type="checkbox"/> >2 drinks/day | |

Tobacco

- | | |
|--|---|
| <input type="checkbox"/> Never | <input type="checkbox"/> Current smoker (<i>how many packs per day?</i>): _____ |
| <input type="checkbox"/> Quit (<i>when did you quit?</i>): _____ | |

Occupation: _____

Marital Status: single married divorced widowed

REVIEW OF SYSTEMS:

- General: weight gain weight loss
- Cardiac: chest pain irregular heart beats
- Pulmonary: shortness of breath sleep apnea exposure to TB
- Urinary: difficulty with urination pain with urination
- Neurologic: seizures blackout spells
- Muscular: joint pain joint swelling
- Hematology: easy bleeding easy bruising