Name:	Birth Date:	Examination Date:

Patient History

Current Problem (please describe symptoms / problems)
Treatments used for this problem (including those not currently in use)
Testing done for this problem (including xray, ultrasound, endoscopy) □ None
Other Physicians treating this problem □ None

History of abdominal pain?.	□Yes □ No	Constipation?	□Yes □ No
Decreased appetite?	□Yes □ No	Diarrhea?	□Yes □ No
Weight Loss?	□Yes □ No	Change in bowel habits?	□Yes □ No
		Rectal Bleeding?	□Yes □ No
Heartburn?	□Yes □ No	Hemorrhoids ?	□Yes □ No
Swallowing Difficulty?	□Yes □ No	History of colon polyps?	□Yes □ No
Food Sticking in chest?	□Yes □ No	History of colon cancer?	□Yes □ No
Cough / Hoarseness?	□Yes □ No	History of colon screening?	□Yes □ No
Nausea / Vomiting?	□Yes □ No	Previous colon polyp/tumor?	□Yes □ No
History of Ulcer disease?	□Yes □ No	Colitis or Crohn's Disease?	□Yes □ No
		Jaundice/hepatitis?	□Yes □ No
History of Pancreatitis?	□Yes □ No	Liver disease or cirrhosis?	□Yes □ No

Vaccination for Hepatitis A?	□Yes □ No	Date:
Vaccination for Hepatitis B?	□Yes □ No	Date:
Vaccination for Pneumonia?	□Yes □ No	Date:
Vaccination for Influenza?	□Yes □ No	Date:

Name:	Birth Date:

Prescription Medications

	Dose	Times a Day
Coumadin Yes No Why?		
Plavix Yes No Why?		

Over the Counter Medications

Include herbals, vitamins, home remedies

□ None

	Dose	Times a Day
Iron Yes No		
Aspirin Yes No		
Advil/Aleve/Headache powders Yes No		

Medication Allergies

	Circle Reaction
	Shortness of breath, hives, rash. Itching, other
	Shortness of breath, hives, rash. Itching, other
	Shortness of breath, hives, rash. Itching, other
	Shortness of breath, hives, rash. Itching, other
	Shortness of breath, hives, rash. Itching, other

Latex Allergy ? Yes / No

Past Medical History

Diabetes	□Yes □ No	Lung Disease?	□Yes □ No	Kidney Disease?	□Yes □ No
High blood Pressure?	□Yes □ No	Asthma?	□Yes □ No	Dialysis?	□Yes □ No
Thyroid Disease?	□Yes □ No	Emphysema?	□Yes □ No		
Glaucoma?	□Yes □ No	Sleep Apnea?	□Yes □ No	Stroke?	□Yes □ No
Infectious Disease?	□Yes □ No			Parkinson's Disease?	□Yes □ No
				Arthritis?	□Yes □ No
Blood Clotting Problems?	□Yes □ No				
Heart Attack?	□Yes □ No				
Heart Murmur?	□Yes □ No				
Heart Failure?	□Yes □ No				
Heart Irregularity?	□Yes □ No				

OTHER MEDICAL ILLNESS? □Yes □ No

If Yes,describe:

Surgical History

Reflux Surgery	□Yes □ No	DATE	Description
Gallbladder	□Yes □ No		
Appendectomy	□Yes □ No		
Hysterectomy	□Yes □ No		
Stomach Surgery	□Yes □ No		
Colon Surgery	□Yes □ No		
Heart Valve	□Yes □ No		
Cardiac Bypass	□Yes □ No		
Cardiac Stent	□Yes □ No		
Pacemaker / Defibrillator	□Yes □ No		
OTHER SURGERY	□Yes □ No		

Social History

Any history of:		
Alcohol?	□Yes □ No	Quit?
Tobacco?	□Yes □ No	Quit?
Coffee/Caffeine?	□Yes □ No	Quit?
Other Drugs?	□Yes □ No	Quit?

Family History

		Relative(s)			Relative(s)
Colon Cancer?	□Y □ N		Uterine Cancer?	□Y □ N	
Colon Polyp?	□Y □ N		Diabetes?	□Y □ N	
Pancreatic Cancer?	□Y □ N		Heart Attack?	□Y □ N	
Ulcerative Colitis?	□Y □ N		Stroke?	□Y □ N	
Crohn's Disease?	□Y □ N				

Systems Review

Constitutional

Have you had fevers or chills? □Yes □ No
Do you feel poorly? □Yes □ No
Do you feel tired? □Yes □ No
Have you gained or lost weight recently? □Yes □ No
How much? _____ (pounds)

Eyes

Do you have eye pain? □Yes □ No
Do you have red eyes? □Yes □ No
Do you have eyesight problems? □Yes □ No
Do you have Discharge from the eyes? □Yes □ No
Do you have Dry eyes? Itching eyes? □Yes □ No

ENT

Have you had earache? □Yes □ No
Loss of hearing? □Yes □ No
Nosebleeds? □Yes □ No
Nasal discharge? □Yes □ No
Sore throat? □Yes □ No
Hoarseness? □Yes □ No

Cardiovascular

Have you had to slow or too fast heart rate? □Yes □ No
Do you have a pacemaker? □Yes □ No
Defibrillator? □Yes □ No
Irregular heartbeat? □Yes □ No
Chest pain? □Yes □ No
Pain in the legs with exercise? □Yes □ No
Swelling of the legs? □Yes □ No

Respiratory

Are you short of breath with exertion? □Yes □ No
At rest? (Y / N) Do you have a cough? □Yes □ No
Wheezing? □Yes □ No
Shortness of breath when lying down? □Yes □ No
Shortness of breath at night? □Yes □ No

Genitourinary

Pain with urination? □Yes □ No
Incontinence of urine? □Yes □ No
(Female) Pelvic pain? □Yes □ No
Vaginal discharge? □Yes □ No
Excessive pain or bleeding with periods? □Yes □ No
(Male) Difficulty initiating urination? □Yes □ No
Nocturnal urination? □Yes □ No

Integumentary

Do you have skin lesions or unusual growth on the skin? □Yes □ No
Rash? □Yes □ No
Itching? □Yes □ No
Change and a mole? □Yes □ No
Dry skin? □Yes □ No

Musculoskeletal

Do you have pains in the joints? □Yes □ No
Joint swelling? □Yes □ No
Joint stiffness? □Yes □ No
Swelling of the extremities or joints? □Yes □ No

Neurological

Do you have confusion? □Yes □ No
Do you have seizures? □Yes □ No
Dizziness? □Yes □ No
Fainting? □Yes □ No
Weakness and an arm or leg? □Yes □ No
Difficulty walking? □Yes □ No

Psychiatric

Do you feel depressed? □Yes □ No
Anxious? □Yes □ No
Had difficulty sleeping? □Yes □ No
A change in personality? □Yes □ No
Emotional problems? □Yes □ No

Endocrine

Do you have thyroid problems? □Yes □ No
Muscle weakness? □Yes □ No
Deepening of the voice? □Yes □ No
Feelings of weakness? □Yes □ No
Hot flashes? □Yes □ No

Hematologic/lymphatic

Do you bleed easily? □Yes □ No
Bruise easily? □Yes □ No
Swollen glands? □Yes □ No
Swollen glands in the neck? □Yes □ No

Additional Comments / Questions

_____
_____
_____
_____
_____
_____
_____
_____