Name: ______________________________ Today's Date ________

DOB ______________________ Who Referred you to our office? ______________________

Please list why are you being seen by our office today: (Please included how long you have had this problem and what makes it worse)

____

____

Please list your current medication: ☐ I have provided a written list of my medication.

Medication	Strength	How Often

Please list all major medical conditions you have or have experienced in the past.

Condition	Date (Month / Year)

Please list any know Allergies ☐ I have no known allergies

Allergy	Type of Reaction

Please list all previous surgeries with approximate dates

Surgery	Date (Month / Year)

Have you had any of the following procedure:

	Yes	No	Date	Where (what location / what provider)
Hidden blood in stool test				
Upper GI X-ray				
Lower GI X-ray (Barium Enema				
CT Scan or MRI of Abdomen				
Sigmoidoscopy				
Colonoscopy				
Upper Endoscopy				

Please list any hospitalizations (other than surgeries) with approximate dates

Hospitalization	Date (Month / Year)

Family History: Are you adopted? Yes No

Family Member	Status A - Alive D - Deceased U - Unknown	Year of Birth	Age (Years)	Known Medical Condition or cause of death
MOTHER	A D U			
FATHER	A D U			
BROTHER / SISTER	A D U			
CHILD	A D U			

Circle : Yes or No (If yes, please list who)		
Family History of: Colon Cancer or Polyps	Yes (Who)	No
Family History of: Crohn's or Ulcerative Colitis	Yes (Who)	No
Family History of: Other Cancers	Yes (Who)	No
Family History of: Liver Disease	Yes (Who)	No

Social History: Do you use tobacco products? Y / N Former If Yes, what type, how often?

Alcohol Use: ______ Heavily ____ Moderately ______ Socially

______ Occasionally ______ Rarely ______ Never

Review of Systems

Do you have any of the following symptoms?

Constitutional:	Yes	No	**Gastrointestinal:**		
Weight Gain	______	______	Frequent Nausea &/or vomiting	______	______
Night Sweats / Hot Flashes	______	______	Diarrhea	______	______
Weight Loss	______	______	Constipation	______	______
Fever Fatigue	______	______	Hemorrhoids	______	______
			Heartburn &/or indigestion	______	______
HEENT			Difficulty swallowing	______	______
Frequent Headaches	______	______	Increased belching or burping	______	______
Double / Blurred vision	______	______	Loss of appetite	______	______
Hearing Loss	______	______	Abdominal Pain	______	______
Glaucoma	______	______	Passing excessive gas	______	______
			Vomiting any blood	______	______
Respiratory			Blood in stool	______	______
Difficulty breathing	______	______	Blood on toilet tissue	______	______
Shortness of breath	______	______	Leaking stool or accidents	______	______
New Cough	______	______	Mucous in your stool	______	______
			Jaundice (skin or whites of eyes)	______	______
Cardiovascular			Any acid reflux (stomach acid	______	______
Chest pain or pressure	______	______	taste) or regurgitation	______	______
Heart Palpitations/fluttering	______	______	Changes in bowel habits	______	______
Heart Murmur	______	______			
			Genitourinary:		
Vascular			Frequent or painful urination	______	______
Leg cramps with walking			Blood in urine		
(Claudication)	______	______		______	______
Change in color of hands or fee			**Neuro / Psychiatric:**		
(Raynaud's)	______	______	Fainting or dizzy spells	______	______
			Emotional Problems	______	______
Dermatologic (Skin)			Convulsions or seizures	______	______
Itching	______	______	Numbness / Tingling	______	______
Any rashes, sores, color changes or					
spots on skin	______	______	**Musculoskeletal**		
			Joint Pain	______	______
Hematology			Back Pain	______	______
Easy bruising or bleeding	______	______			
Frequent nose bleeds	______	______			

Females Only:

Reproductive	Yes	No
Menstrual difficulty	______	______
Menstrual flow more than 5 days	______	______
Menstrual Periods more frequent than every 4 weeks	______	______

Have you ever had or do you have any of the following: (check if YES)					
______	Alcoholism	______	Crohn's Disease	______	Kidney Disease
______	Anemia	______	Diabetes	______	Liver Problems
______	Angina/ Heart attack	______	Emphysema	______	Lung Problems
______	Arthritis	______	Epilepsy or Seizures	______	Lupus / RA
______	Artificial Heart Valve	______	Glaucoma	______	Mental Illness
______	Asthma / Hay Fever	______	Headaches	______	Sleep apnea
______	Atrial Fibrillation	______	Heart bypass	______	Stroke
______	Birth Defects	______	Heart Disease	______	Thyroid Problem
______	Bladder Disease	______	Heart Stent	______	Tuberculosis
______	Bleeding Disorder	______	Hepatitis	______	Other: _____________
______	Cancer: _____________	______	High Blood Pressure	______	Other: _____________
______	Colitis	______	HIV / AIDS		