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	