Today's Date _____

Name: _____ Birth Date: _____

Check all that apply:

___ Abdominal Pain ___ Appetite Poor ___ Bloating ___ Bowel Changes
___ Constipation ___ Diarrhea ___ Gas ___ Heartburn
___ Indigestion ___ Hemorrhoids ___ Nausea ___ Vomiting

Past Medical and Surgical history: List surgeries you have had and the year:

1._____ 4._____
2._____ 5._____
3._____ 6._____

Medications: List medications you are currently on:

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

Allergies: to medication or substances:

1._____ 3._____
2._____ 4._____

Family History: Please complete the health information about your family.

	Age	state of health	age at death	cause of death
Father:	____	_____	_____	_____
Mother:	____	_____	_____	_____
Brother	____	_____	_____	_____
Sister	____	_____	_____	_____

Women only: Pregnancy History:
Number of Pregnancies: ____ # of Vaginal Deliveries____ # of C-Sections _____

Check the substance you use and describe how much you use:

Yes No Caffeine ___ Coffee ___ Tea _____ Other _____Cups Daily
Yes No Tobacco ____ # of packs a daily
Yes No Alcohol What Type: ___ Beer ___ Wine ___ Liquor
Yes No Drug Abuse What Type: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Patient Signature Date

_____ _____
Physician Signature Date Reviewed