Today's Date _____

Name: _____ Birth Date: _____

Primary reason for visit:

_____
_____
_____

Check all that apply:

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

___ Difficulty swallowing
___ Pain with swallowing
___ Unintentional weight loss

Past Medical History (Please circle and list additional medical problems)

1. (YES / NO) Diabetes
2. (YES / NO) Hypertension (high blood pressure)
3. (YES / NO) Abnormal cholesterol.
4. (YES / NO) Heart attack
4. (YES / NO) Stroke
5. (YES / NO) Cancers
6. (YES / NO) Transfusion of blood products
7. _____
8. _____
9. _____
10. _____

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

Past Surgical History (please list surgery with year)

1. (YES / NO) Prior upper endoscopy (year, indication & results) _____
2. (YES / NO) Prior colonoscopy (year, indication & results) _____
3. (YES / NO) Appendectomy _____
4. (YES / NO) Cholecystectomy (Gallbladder removal) _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Social History

1. Occupation
2. (YES / NO) Tobacco now or in the past _____ amount? ☐
3. (YES / NO) Alcohol now or in the past _____amount and frequency? ☐
4. (YES / NO) Drug abuse now or in the past
5. (YES / NO) Travel outside USA in the past year.

Family History

1. (YES / NO) Cancer
2. (YES / NO) Polyps
3. (YES / NO) Liver disease
4. (YES / NO) Ulcerative colitis / Crohn's disease
5. (YES / NO) Gastrointestinal diseases

	Age	Medical problems	age at death	cause of death
Father:	____	_____	_____	_____
Mother:	____	_____	_____	_____
Brother	____	_____	_____	_____
Sister	____	_____	_____	_____

Allergies (please specify reaction):

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

Medications:

1. (YES / NO) Aspirin
2. (YES / NO) BC Powder
3. (YES / NO) Goody's Powder
4. (YES / NO) Ibuprofen / Motrin
5. (YES / NO) Naproxen / Aleve
6. (YES / NO) Herbal medication

9._____
10._____
11._____
12._____
13._____
14._____

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

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