



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