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) Tobbacco 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