Patient Name_____ **Date**_____ **Referring M.D.**_____

Birth date ___/___/_____ **Age**_____ **Explain your reason for the visit**: _____

Occupation_____ _____

Married ☐ Divorced ☐ Single ☐ Widowed

_____

_____

_____

_____

_____

- **Abdominal pain** □ **No** □ **yes** **Intensity** of the pain/ Mild /moderate/ severe __ /10 Scale [1/10 ---10] /10
  Date of onset: _____Onset sudden/slow_____Constant or intermittent _____
  Duration /seconds/ min/hours_____ Frequency:_____Character of pain_____
  Aggravated by:_____ Relieved by:_____
  Relationship to Food/hunger_____Relationship to bowel movement_____
  Location: _____Radiation_____

- **Vomiting** □ No □ yes undigested food / acid sour / bile / bitter/ Food eaten several hours or days back
- **Vomitingblood** □No □yes Red/coffeegrounds □No □yes Black tarry stool □ No □yes _____

_____

• **Heartburn or acid reflux**	□ No □ yes	Frequency _____day/week/month/year: _____ Nocturnal: □ No □yes
• Difficulty swallowing since___	□ No □ yes	Intermittent____Progressive ____ Location_____ solids _____Liquids_____
• Pain on swallowing	□ No □ yes	_____
• Decrease in appetite	□ No □ yes	_____Aspiration □ No □ yes Pnuemonia □ No □ yes _____
• **Diarrhea** Date of onset_____	□ No □ yes	large/small; during the day; Day & night; Relationship to Food _____
• Blood in stool	□ No □ yes	Top of the stool _____Mixed in stool _____
• Excess Mucous in stool	□ No □ yes	_____
• Pain on passage of stool	□No □yes	_____
• Incomplete stool passage	□ No □ yes	_____
• Constipation	□ No □ yes	# bowel movements per week_____
• Gas or bloating	□ No □ yes	
• Incontinence "accidents"	□ No □ yes	
• Jaundice	□ No □ yes	_____Dark urine□ No □ yes_____ Pale stool □ No □ yes
• Hepatitis	□ No □ yes	_____
• Itching all over the body	□ No □ yes	_____
• Abdominal distention	□ No □ yes	_____
• Easily bruised	□ No □ yes	_____
• Confusion	□ No □ yes	_____
• Weight gain	□ No □ yes	_____

Medications: (Prescription, vitamins & over-the-counter)

1. _____	**2.** _____	**3.** _____
4. _____	**5.** _____	**6.** _____
7. _____	**8.** _____	**9.** _____
10. _____	**11.** _____	**12.** _____
13. _____	**14.** _____	**15.** _____

Do you take any of the following OTC medications? □ No □ Yes, if so which ones and how often:

ASPIRIN MOTRIN ADVIL ALEVE IBUPROFEN ANACIN EXCEDRIN

Daily _____ # Weekly _____ # Monthly _____ # as needed/ what for? _____

Surgeries:	**Year:**	**Medication Allergies** Type of reaction (such as rash or breathing)
1. _____	_____	**1.** _____
2. _____	_____	**2.** _____
3. _____	_____	**3.** _____
4. _____	_____	**4.** _____
5. _____	_____	**5.** _____

Other Illnesses (Diabetes/ High blood pressure/ Heart disease etc) **Year Diagnosed**

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

Family History: circle relation and enter age diagnosed in the space

Colon Cancer:	Father_____	Mother_____	Son_____	Daughter_____	Grandpa_____	Grandma_____	Uncle_____	Aunt_____
Colon Polyps:	Father_____	Mother_____	Son_____	Daughter_____	Grandpa_____	Grandma_____	Uncle_____	Aunt_____
Colitis:	Father_____	Mother_____	Son_____	Daughter_____	Grandpa_____	Grandma_____	Uncle_____	Aunt_____
Crohn's:	Father_____	Mother_____	Son_____	Daughter_____	Grandpa_____	Grandma_____	Uncle_____	Aunt_____
Liver Disease:	Father_____	Mother_____	Son_____	Daughter_____	Grandpa_____	Grandma_____	Uncle_____	Aunt_____
Pancreas cancer:	Father_____	Mother_____	Son_____	Daughter_____	Grandpa_____	Grandma_____	Uncle_____	Aunt_____
StomachUlcer:	Father_____	Mother_____	Son_____	Daughter_____	Grandpa_____	Grandma_____	Uncle_____	Aunt_____
Stomach Cancer:	Father_____	Mother_____	Son_____	Daughter_____	Grandpa_____	Grandma_____	Uncle_____	Aunt_____

Current Illnesses of Family Members (if deceased -age's and cause):

Father:_____ Mother: _____

Brothers:_____ Sisters: _____

Uncles/Aunts:_____ Grandparents:_____

Children:_____ Grandchildren:_____

Patient's Signature_____ **Date**_____

Personal:
SmokeTobacco: □ Never □ Yes _____# of years _____ Packs Per Day _____ Year quit_____
Chew Tobacco: □ Never □ yes _____# of years _____ Packs Per Day _____ Year quit_____

Alcohol use: □ Never □ Socially □ Rarely □ Regularly _____ # of years ____Drinks Per Week _____Year quit □ Alcohol Dependent

Tattoos: □ None □ yes Where/who placed it from_____ When was it placed_____
Body piercing
IV Drug use: □ Never □ yes When last used _____
Inhalation drug use □ Never □ yes When last used _____

High Risk Sexual Behavior: □ no, only one partner ever □ yes, multiple partners/unprotected sex (ever)

Sexual orientation _____

Blood Transfusion: □ Never □ yes Year of transfusion _____ where _____ Transfusion before 1990 □ yes □ No

Cups of Coffee #Daily _____# Weekly_____
Cups of Soda #Daily _____ # Weekly_____
Chewing Gum □No □yes occasionally □ yes daily/how often_____

Health Food/ Herbal product use:

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

Endoscopy History:
- Date of last Colonoscopy _____ By Whom/hospital/City/ State _____
- Results/Findings _____ Recommendations _____
  - Previous colonoscopies (Year)_____
- Date of last EGD (stomach scope) _____ By Whom/ hospital/City, State _____
- Results/Findings _____ Recommendations _____

Radiological History:
□ Barium Swallow (X-ray) Date _____ Location _____ Results _____
□ Barium Enema (X-ray) Date _____Location_____ Results _____
□ Abdominal Ultrasound Date _____Location _____ Results _____
□ CT Scan (abd/pelvis) Date _____ Location _____ Results _____
□ MRI (abd/pelvis) Date _____ Location_____ Results_____

Patient's Signature_____ Date_____

Please indicate *yes or no* **as we are not able to assume your response to the following pages. A line or check will let us know that you have read and understood the symptoms listed.**

REVIEW OF SYSTEMS	**NO**	**YES, COMMENTS**
Constitutional		
● > 10 lb. weight loss in past year	_____	_____
● > 10 lb. weight gain in past year	_____	_____
● Fever within past month	_____	_____
● Chills or sweats within past month	_____	_____
● Chronic fatigue	_____	_____
● Anorexia/ poor appetite	_____	_____
Eyes		
👁 Blurred or double vision	_____	_____
👁 Cataracts or glaucoma	_____	_____
👁 Frequent red eye	_____	_____
Ears, Nose, Mouth Throat		
👂 Hearing Loss	_____	_____
👂 Ringing in the ears	_____	_____
👂 Sore Throat/hoarseness	_____	_____
👂 Sinus problems	_____	_____
👂 Nose Bleeds	_____	_____
Cardiovascular		
♥ Chest pain or pressure	_____	_____
♥ Rapid or irregular heart beat	_____	_____
♥ Abnormal swelling in legs or feet	_____	_____
♥ High blood pressure	_____	_____
♥ Vascular disease	_____	_____
♥ Coronary Artery Disease	_____	_____
♥ Difficulty breathing	_____	_____
Respiratory		
🧍 Shortness of breath	_____	_____
🧍 Wheezing or Asthma	_____	_____
🧍 Persistent cough	_____	_____
🧍 Coughing up sputum or blood	_____	_____
🧍 Exposed to Tuberculosis	_____	_____
🧍 Difficulty breathing on exertion	_____	_____
🧍 Chronic Bronchitis/Emphysema	_____	_____
Genitourinary		
🚽 Frequency of urination	_____	_____
🚽 Difficulty starting urinary stream	_____	_____
🚽 Leaking urine	_____	_____
🚽 Burning/pain with urination	_____	_____
🚽 Blood in urine	_____	_____
🚽 Urinary tract infections	_____	_____
🚽 Stones or kidney problems	_____	_____

Patient's Signature_____ **Date**_____

REVIEW OF SYSTEMS	NO	YES, COMMENTS
Musculoskeletal		
Pain/stiffness/swelling in joints	_____	_____
Morning Stiffness	_____	_____
Chronic Backaches	_____	_____
Osteoporosis	_____	_____
Neurological		
Frequent headaches	_____	_____
Dizziness	_____	_____
Problems with balance	_____	_____
Numbness or tingling	_____	_____
Seizures	_____	_____
Blacked-out or lost consciousness	_____	_____
slurred speech	_____	_____
Skin/Breast		
Skin rashes/cancer	_____	_____
Breast mass/discharge	_____	_____
Psychiatric		
•Anxiety	_____	_____
•Memory loss	_____	_____
•Depression	_____	_____
•Suicidal ideation	_____	_____
•Mental Illness	_____	_____
Endocrine/Metabolic		
✦ Excessive thirst/urination	_____	_____
✦ Diabetes	_____	_____Onset_____
✦ Thyroid Disease	_____	_____Onset_____
✦ Menses	_____	Heavy / scant Stopped at age _____
✦Vaginal bleeding	_____	_____
✦High cholesterol/Triglycerides	_____	_____
Hematologic/Lymphatic		
Enlarged glands (lymph nodes)	_____	_____
Excessive bruising	_____	_____
Abnormal bleeding	_____	_____
Anemia	_____	_____

Patient's Signature_____ **Date**_____