

Name: _____ Age: _____ Date: _____

Reason for today's visit: _____

Please check box for any medical problems:

<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Breast Cancer
<input type="checkbox"/> Seizure	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Prostate Cancer
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Arthritis	
<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Depression/Anxiety	
<input type="checkbox"/> Asthma	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Anemia	

Other Conditions _____

Please check box for prior surgeries/procedures (please include endoscopy procedures):

<input type="checkbox"/> Tonsils	<input type="checkbox"/> Hip Replaced	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Hysterectomy (uterus removed)
<input type="checkbox"/> Heart Bypass	<input type="checkbox"/> Knee Replaced	<input type="checkbox"/> Colon Surgery	<input type="checkbox"/> Hernia
<input type="checkbox"/> Heart Valve	<input type="checkbox"/> C-section	<input type="checkbox"/> Colonoscopy	
<input type="checkbox"/> Back Surgery	<input type="checkbox"/> Appendix	<input type="checkbox"/> Upper Endoscopy	

Other Surgeries _____

Family Medical History
 List any medical problems that run in your family and who had them: _____

Has anyone in your family had uterine, ovarian, and/or colon cancer? Yes No (If yes, which form of cancer, who & at what age?) _____

Has anyone in your family had Crohn's disease, colitis, or pancreatic cancer? Yes No (If yes, who & at what age?) _____

Social
 Who do you live with? _____
 Are you? Married Single Divorced Widowed
 Are you employed? Yes No If yes, what is your job? _____
 Are you disabled? Yes No If disabled, reason? _____

Habits
 Do you smoke? Yes No If yes, how many packs per day? _____
 Did you smoke in the past? Yes No If yes, when did you quit? _____
 Do you drink alcohol? Yes No If yes, how many drinks per week? _____
 Do you chew tobacco? Yes No
 How many cups of coffee per day? 0 1-2 3-4 >4
 How many cans of soda per day? 0 1-2 3-4 >4

Please list your current medications and dosages: _____

Allergies: _____

Do you take Goody's or BC's Ibuprofen (Advil, Motrin, Nuprin, Aleve, or similar medicine)
 None
 If yes, how many pills per week? _____

If there is anything else about your health you would like us to be aware of, please mention it here: _____

Preventative Care
 Have you ever had a colonoscopy for colorectal cancer screening? _____

Please answer some questions about your general health.

Date: _____

Gen	Do you have any weight problems? Have you lost weight recently? Have you gained weight? Any fever or sweating chills?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, how many lbs? _____ <input type="checkbox"/> No <input type="checkbox"/> Yes, how many lbs? _____ <input type="checkbox"/> No <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None	Please explain below symptoms you have currently:
Eyes	Do you have trouble with your vision? (other than needing glasses) Do you have glaucoma?	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None	
ENT	Do you have hearing trouble? Recurrent nosebleeds? Sinus problems? Hoarseness?	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None	
CV	Do you have chest pain or angina? Shortness of breath? Passing out spells? Swelling of your ankles?	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None	
GI	Do you have heartburn? If yes, <input type="checkbox"/> daily <input type="checkbox"/> weekly <input type="checkbox"/> less than once a week Do you have difficulty swallowing? Nausea? Vomiting? Diarrhea? Constipation? Uncontrolled leakage of stool? Rectal bleeding? Black stools that look like tar? Have you ever had hepatitis or jaundice?	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None	
GU	Do you currently have <input type="checkbox"/> painful or <input type="checkbox"/> frequent urination Blood in your urine? Have you had kidney stones? Abnormal menstrual bleeding? (women only)	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None	
MS	Do you have Joint pain or arthritits? Back pain? Prominent muscle sorness or aches? If yes, where?	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None	
NEU	Frequent headaches? Have you had seizures? Have you ever had a stroke?	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None	
HEME	Have you ever had a blood transfusion? Do you have severe bleeding tendencies? If yes, please explain:	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None	
PSYCH	Are you depressed? If yes, would you call this depression: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Do you have problems with your nerves or feel under excessive stress? If yes, would you call this stress/nerves: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Have you ever been a victim of sexual or physical abuse?	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> None	