Patient Name:____ **Today's date:**________________

Date of Birth:______________ **Age :**_______ **Current Height:**______________ **Current Weight:**_____________

Reason for today's visit: ____

Are you currently experiencing any of the following?

_ Anal itching
_ Anal Pain
_ Anal Swelling or protrusion
_ Anal Drainage
_ Abdominal Pain
_ Abdominal Swelling/Distension
__ Bleeding with bowel movements
__ Change in size of stool
__ Change in stool frequency
__ Constipation
__ Diarrhea
__ Incontinence
__ Need for laxatives
__ Pain with bowel movements
__ Trouble controlling stool/gas
__ Unintentional weight loss
__ Other

Allergy List:

Allergy	Reaction

Medication List: ***Please list all current medications, including vitamins, supplements and dosages: (Can send separate sheet)***

Name	Dose	Frequency

Family Medical History: (who?)

Has anyone in your family had any of the following? (Specify which relative, if any were under age 50, please indicate):

PROBLEMS WITH ANESTHESIA:____________

Breast Cancer:____________________________

Colorectal Cancer:____________________**Under 50y?**__________

Colon Polyps:____

Crohn's Disease:_______________________________________

Ulcerative Colitis:______________________________________

Ovarian Cancer:______________________**Under 50y?**__________

Uterine/Endometrial Cancer:_____________________________

Patient Surgical History:____

Patient's Last Colonoscopy (Date):_______________ **What was Found?:**______________________________

Social History:

Tobacco: ◯ Current smoker/daily ◯ Current smoker/sometimes ◯ Former smoker ◯ Never

Alcohol Use: ◯ Yes ◯ No ◯ Social ◯ Daily ◯ History of Addiction

Do you have/ need any of the following? ◯ Glasses ◯ Contact Lenses ◯ Denture (Upper/ Lower) ◯ Capped Teeth ◯ Hearing Aid ◯ Partial Bridge ◯ Assistance Walking

Any cultural or religious concerns:______________________________________

Patient Name:____**Date Of Birth:**________________

Primary or Referring Doctor:____

Past Medical History: Please check **YES** if you have experienced any of the following conditions/symptoms; otherwise check **NO.**

General	YES	NO	Musculoskeletal	YES	NO
Problems w/ anesthesia (describe)			Arthritis (specify type):		
Antibiotics for dental work			Back pain/injury		
Recent Cold/Flu/Sore throat			Fibromyalgia		
Recent Fever			Lupus		
Recent Hospitalization (list)			Gout		
Recent injury			◯ Osteopenia/◯ Osteoporosis		
Cardiac (Heart Problems)			**Pulmonary (Respiratory)**		
◯ Pacemaker			Asthma		
◯ Defibrillator			Deep Vein Thrombosis		
◯ Stents			Pulmonary Embolism		
◯ Angioplasty			Bronchitis		
Arrhythmia			Emphysema/COPD		
Atrial Fibrillation			Hay fever		
Chest Pain (outcome & diagnosis)			Home oxygen		
Heart attack (MI)			Seasonal allergies		
High Cholesterol			Shortness of breath		
Hypertension (High Blood Pressure)			Sleep Apnea		
Mitra! Valve Prolapse			**Kidney/Urinary Problems**		
Palpitations			ESRD/Dialysis (type):		
			Frequent urination		
GI (Intestinal Problems)			Incontinence		
Anal cancer			Kidney stones		
Anal Fissure			Prostate enlargement		
Anal Fistula			Prostate cancer		
Anal Warts (Condyloma)			**Neurological**		
Colon/Rectal Cancer			Migraine headaches		
Colon/Rectal Polyps			Multiple Sclerosis		
Crohn's Disease			Seizure disorder		
Diverticulitis (infection)			Stroke		
Diverticulosis			TIA		
Irritable Bowel Syndrome (IBS)			**Endocrine**		
◯ Reflux / ◯ Peptic Ulcer			Diabetes Mellitus-Type I		
Ulcerative colitis			Diabetes Mellitus-Type II		
			Graves disease		
Psychiatric History			Hyperthyroid (high)		
ADD / ADHD			Hypothyroid (low)		
Anxiety			**Ophthalmology (Eyes)**		
Bipolar Disorder			Cataracts		
Depression			Glaucoma		
Eating disorder			Glasses/contact lenses		
Schizophrenia			**Hematology (Blood)**		
Infection History			Anemia		
Genital Herpes			Bleeding disorder (type):		
Hepatitis – A, B, or C (circle)			**Gynecology (GYN)**		
HIV / AIDS			Endometriosis		
MRSA			Fibroids		
Tuberculosis			**Oncology (Cancer): List:**		

Please add any other medical conditions not listed on this form:____________________________________

____