

Patient Name: _____ Today's date: _____

Date of Birth: _____ Age : _____ Current Height: _____ Current Weight: _____

Reason for today's visit: _____ PCP _____

Are you currently experiencing any of the following? Is/Are these new symptoms: Yes No

- Screening Colonoscopy
- Anal Pain/itching
- Anal Swelling or protrusion
- Anal Drainage
- Abdominal Pain
- Abdominal Swelling/Distension
- Other: _____
- 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
- Anemia last Hg _____

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):

- Colorectal Cancer: _____ Under 50y? _____
- Colon Polyps: _____
- Crohn's Disease: _____
- Ulcerative Colitis: _____
- Ovarian Cancer: _____ Under 50y? _____
- Uterine/Endometrial Cancer: _____

PROBLEMS WITH ANESTHESIA: _____

Breast Cancer: _____

Patient Surgical History: _____

Patient's Last Colonoscopy (Year?): _____ What was Found?: Polyps? Diverticulosis? _____

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: _____

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			<input type="radio"/> Osteopenia/ <input type="radio"/> Osteoporosis		
Cardiac (Heart Problems)			Pulmonary (Respiratory)		
<input type="radio"/> Pacemaker			Asthma		
<input type="radio"/> Defibrillator			Deep Vein Thrombosis		
<input type="radio"/> Stents			Pulmonary Embolism		
<input type="radio"/> Angioplasty			Bronchitis		
Arrhythmia			Emphysema/COPD		
Atrial Fibrillation			Hayfever		
Chest Pain (outcome & diagnosis)			Home oxygen		
Heart attack (MI)			Seasonal allergies		
High Cholesterol			Shortness of breath		
Hypertension (High Blood Pressure)			Sleep Apnea		
Mitral 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		
<input type="radio"/> Reflux / <input type="radio"/> 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: _____