

PATIENTS PERSONAL HISTORY

Today's Date: _____

Patient Name: _____ DOB: _____

(Last Name First Middle)

Place of Birth: _____ SSN: _____

Sex: _____ Marital Status: _____ Religion: _____

Address: _____

(Address City State Zip)

Home #: _____ Cell #: _____

Primary Insurance: _____ Secondary Insurance: _____

Employer Name & Phone #: _____

Emergency Contact: _____ Phone#: _____

Emergency Contact Address: _____

Family or Referring Physician: _____

FAMILY HISTORY

(If living please give age and health-----If deceased please give age at death and cause)

Mother: (Living / Deceased) _____

Father: (Living / Deceased) _____

How many Brothers/Sisters: _____

How many Sons/Daughters: _____

Do you know of any blood relative who has or had: (Circle and give relationship)

Colon Cancer (YES / NO) Any other Cancer (YES / NO) Colitis (YES / NO) Crohn's Disease (YES / NO)

Any other illness in the Family? _____

PERSONAL HABITS: (Circle)

Do you smoke? (YES / NO) Cigarettes _____ Pipe _____ Cigars _____ How many years? _____

Do you regularly drink alcohol / Beer? (YES / NO) Amount & Frequency: _____

Briefly describe reason for your visit today: _____

List all your medical problems: _____

PATIENTS PERSONAL HISTORY

List previous surgeries that you have had: _____

PLEASE LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING (Include all over-the-counter or non-prescription)

Name any drugs to which you are allergic: _____

List all doctors you are currently seeing: _____

REVIEW OF SYSTEMS

GI:

Rectal Bleeding (YES / NO)	Black Stools (YES / NO)	Change in Bowel Habits (YES / NO)
Abdominal Pain (YES / NO)	Loss of Appetite (YES / NO)	Heartburn (YES / NO)
Nausea/Vomiting (YES / NO)	Regurgitation (YES / NO)	Trouble Swallowing (YES / NO)

CVS:

Chest Pain (YES / NO)	Heart Attack (YES / NO)	Palpitations (YES / NO)
Valve Replacement (YES / NO)		

RS:

Shortness of Breath (YES / NO)	Wheezing (YES / NO)	Cough-(Blood in Sputum) (YES / NO)
Hoarseness of Voice (YES / NO)		

CNS:

Previous Stroke (YES / NO)	Weakness (YES / NO)	Seizures (YES / NO)
Fainting Attacks (YES / NO)	Headache (YES / NO)	

OTHER:

Kidney Failure (YES / NO)	Trouble with Urination (YES / NO)
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HAVE YOU HAD A COLONOSCOPY? _____ IF SO, WHEN? _____

HAVE YOU HAD AN UPPER ENDOSCOPY? _____ IF SO, WHEN? _____