

Patient History Form

Name _____ Date of Birth _____ Age _____ Male/ Female _____

Who is your primary care doctor? _____ Height _____ Weight _____

List all allergies: _____

Allergic to Latex? _____

Medical Problems (√ if yes)

| | | | |
|---|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Stomach ulcer |
| <input type="checkbox"/> Cancer type _____ | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Colon cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Colon polyp | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Reflux disease | <input type="checkbox"/> Ulcerative colitis |

Other medical problems _____

Surgeries/Hospitalizations (and dates)

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Have you ever had a flexible sigmoidoscopy? Yes/No _____ If Yes, Please give the date _____

Have you ever had a colonoscopy? Yes/ No _____ If Yes, Please give the date _____

Have you ever had an upper endoscopy? Yes/No _____ If Yes, Please give the date _____

List your current medications and doses (including over the counter)

Please leave "Last Dose" Blank. If you have a procedure, the nurse will assist you with this section.

| | | |
|----------|--------------|-----------------|
| 1. _____ | Dosage _____ | Last Dose _____ |
| 2. _____ | Dosage _____ | Last Dose _____ |
| 3. _____ | Dosage _____ | Last Dose _____ |
| 4. _____ | Dosage _____ | Last Dose _____ |
| 5. _____ | Dosage _____ | Last Dose _____ |
| 6. _____ | Dosage _____ | Last Dose _____ |
| 7. _____ | Dosage _____ | Last Dose _____ |
| 8. _____ | Dosage _____ | Last Dose _____ |
| 9. _____ | Dosage _____ | Last Dose _____ |

Pharmacy _____ Phone # _____

(ONLY ONE PLEASE)

Social history and habits

Married? (Y/N) _____ Current occupation _____

Children? (Y/N) _____ Ages _____

Do you smoke or chew tobacco? (Y/N) _____ How Much? _____

Do you drink alcohol? (Y/N) _____ How much and how often? _____

Have you ever used street drugs or recreational drugs? _____

Do you have any problems at home due to illness? _____

Patient Name: _____

Date _____

Family history

Father: Age _____ Living – Illness _____ Deceased – Cause of Death _____

Mother: Age _____ Living – Illness _____ Deceased – Cause of Death _____

Brothers: Number _____ Any illnesses? _____

Sisters: Number _____ Any illnesses? _____

Have any of your close relatives (parents, grandparents, brothers, sisters, children) had:(√ if yes)

- Arthritis
- Bleeding disorders
- Cancer type _____
- Colon cancer? Who _____
- Colon polyps? Who _____
- Crohn’s disease
- Diabetes
- Gallstones
- Heart Disease
- Liver disease
- Lung disease
- Pancreatitis
- Stomach ulcer
- Stroke
- Ulcerative colitis

Do other diseases occur in your family? _____

PATIENT CURRENT REVIEW OF SYSTEMS

Constitutional

- Fatigue _____no ___yes
- Fever _____no ___yes
- Night sweats _____no ___yes
- Recent weight loss _____no ___yes

Eyes

- Blurred vision _____no ___yes
- Glaucoma _____no ___yes
- Wear Contacts/Glasses _____no ___yes

Ears/Nose/Mouth/Throat

- Hearing loss _____no ___yes
- Hearing Aid _____no ___yes
- Hoarseness _____no ___yes
- Nose bleeds _____no ___yes
- Sinus problems _____no ___yes
- Sore throat _____no ___yes

Cardiovascular

- Antibiotic prior to dental work _____no ___yes
- If yes, why _____
- Chest pain _____no ___yes
- Irregular heartbeat _____no ___yes
- Pacemaker/Defibrillator _____no ___yes
- Stents _____no ___yes
- Shortness of breath _____no ___yes
- Swelling of ankles _____no ___yes

Gastrointestinal (Symptoms within the past year)

- Abdominal pain _____no ___yes
- Belching _____no ___yes
- Black, tarry stools _____no ___yes
- Bloating _____no ___yes
- Change in bowel habits _____no ___yes
- Constipation _____no ___yes
- Diarrhea _____no ___yes
- Difficulty in swallowing _____no ___yes
- Heartburn _____no ___yes
- Hepatitis _____no ___yes
- Nausea _____no ___yes
- Poor appetite _____no ___yes
- Rectal Bleeding _____no ___yes
- Regurgitation _____no ___yes
- Vomiting _____no ___yes

Neurological

- Headaches _____no ___yes
- Numbness _____no ___yes
- Brain/ Spinal Cord Disease _____no ___yes
- Or Injury _____no ___yes
- Seizures _____no ___yes
- Parkinson’s _____no ___yes
- Alzheimer’s _____no ___yes
- Multiple Sclerosis _____no ___yes
- Strokes _____no ___yes

Respiratory

Chronic cough _____no ___yes
Wheezing _____no ___yes
Positive TB Skin Test _____no ___yes
Use Oxygen @ Home _____no ___yes

Genitourinary

Blood in urine _____no ___yes
Burning with urination _____no ___yes
Frequent urination _____no ___yes
_____no ___yes

Musculoskeletal

Back pain _____no ___yes
Joint pain or swelling _____no ___yes
Muscle pain _____no ___yes
Joint Replacements _____no ___yes

Dental

Bridges/Crowns/Dentures _____no ___yes
Loose Teeth _____no ___yes

Psychiatric

Anxiety _____no ___yes
Depression _____no ___yes
Memory loss or confusion _____no ___yes

Hematological

Anemia _____no ___yes
Bleeding or bruising tendency _____no ___yes
Past blood transfusion _____no ___yes

Skin

Itching _____no ___yes
Rash _____no ___yes
Are you pregnant? _____no ___yes

Airway

Sleep Apnea _____no ___yes
Use C-PAP _____no ___yes
Difficulty opening mouth _____no ___yes
Difficulty turning head _____no ___yes

Other Pertinent Information _____

Patient Signature: _____ Date: _____

If you are scheduled for a colonoscopy, flexible sigmoidoscopy or EGD, the information on this form must be updated within 30 days of having the procedure.

(This update can be done on the day of the procedure.)

Please check one of the following boxes:

I have reviewed this form; there are: no changes changes

If changes, please list: _____

Patient Signature: _____ Date: _____

Form Reviewed by _____ on _____

Form Reviewed by _____ on _____

Revised: Feb 2009