Patient Name: ______________________________

Date of Birth: ______________________________

MEDICAL HISTORY FORM

REASON FOR VISIT TODAY: ____

ALLERGIES/REACTIONS – Please list any allergies or reactions to medications, foods, latex or dyes. Please list what type of reaction you experienced (example: difficulty breathing, hives, etc)

MEDICATIONS – Please list all your medications and doses. Include vitamins, herbal supplements and over the counter medications (for example: Ibuprofen, Advil, Aleve, Aspirin, Excedrin, Motrin, etc)

Medication	Dosage	How often taken

FAMILY HISTORY OF CANCER – Please list all family history of cancer known (Colon Cancer, Endometrial Cancer, Bile Duct Cancer, Kidney, Ureter or Bladder Cancer, Pancreatic Cancer, Esophageal Cancer, Liver Cancer, Brain Cancer, etc)

Cancer Type	Relation	Age of onset	Age of death

SOCIAL HISTORY – Please circle your responses and fill in the blanks where applicable

What is your occupation: ______________________________

Are you able to care for yourself? YES / NO

Please Circle One: MARRIED / SINGLE / DIVORCED / SEPARATED / WIDOWED / PARTNER

Are you a current smoker: YES / NO → If yes, please list # of Yrs: ____ Packs a day:______

Are you a former smoker: YES / NO → If yes, please list # of Yrs: ____ Packs a day:______ Year quit:_______

Do you chew tobacco? YES / NO / Former

Do you drink: YES / RARELY / NO → If yes, please list Amount Per Day _____ OR Amount Per Week ______

Do you currently use recreational drugs? YES / NO

Have you ever used IV drugs? YES / NO

Smokeless Tobacco Status (ie. chewing tobacco)? Never used/Former user/Current user

E-Cigarette/Vape Status? Never used/Former user/Current user

SURGICAL HISTORY : Please list ANY surgeries/procedures and **WHEN** (year it was done) and **WHERE** (location and/or doctor's name) were it was done:

Date of Colonoscopy:	**Dr:**	**Date of Upper Endoscopy:**	**Dr:**
Other Surgeries or Procedures: Do you have a Pacemaker in place?		Ever had heart stents placed? If so, when?	

Patient Name: ______________________________

Date of Birth: ______________________________

MEDICAL HISTORY FORM

PAST MEDICAL HISTORY – Please place a checkmark next to the conditions that you have or have had							
	Anemia		COPD		Hepatitis		Pulmonary Embolism
	Anxiety Disorder		Coronary Artery Disease		HIV		Seizures/Epilepsy
	Arthritis		Depression		Hyperlipidemia		Sleep Apnea
	Asthma		Defibrillator or Pacemaker		Hypertension		Stroke
	Barrett's esophagus		Diabetes		Hyperthyroidism		Tuberculosis
	Bleeding Disorder		Dialysis		Hypothyroidism		Ulcerative Colitis
	Cancer- list type in other		Diverticulitis or Diverticulosis		Kidney Disease	**Please list any others:**	
	Cirrhosis		GERD/Reflux		Liver Disease		
	Crohn's Disease		Gallstones		Osteoporosis/Osteopenia		
	Colon Cancer		Heart Attack		Pancreatitis		
	Colon Polyps		Heart Disease		Pacemaker		

REVIEW OF SYSTEMS – Please place a checkmark in the box next to the symptoms you have had recently					
Constitutional		**Gastrointestinal**		**Neurologic**	
	Fever		Difficulty swallowing		Weakness
	Chills		Pain on swallowing		Numbness
	Night Sweats		Indigestion/Heartburn		Memory loss
	Weight gain		Bloating		Headaches
	Weight loss		Belching		Dizziness
	Fatigue		Regurgitation	**Psychiatric**	
Ears/Nose/Mouth/Throat/Eyes			Nausea		Confusion
	Earache		Vomiting		Depression
	Ringing in ears		Decreased appetite		Anxiety
	Loss of hearing		Early satiety		Nervousness
	Nose/Sinus issues		Abdominal pain		Insomnia
	Nosebleeds		Diarrhea	**Endocrine**	
	Snoring		Fecal incontinence		Cold intolerance
	Sore Throat		Constipation		Heat intolerance
	Hoarseness		Blood in stool		Excessive thirst
	Mouth sores		Black or tarry stools		Increase in urinary frequency
	Feeling of foreign body in throat		Intolerance to dairy	**Musculoskeletal**	
	Change in Taste		Pain when defecating		Muscle Aches
	Loss of Vision		Rectal pain		Weakness
Cardiovascular			Rectal bleeding		Joint Pain
	Fainting/lightheadedness		Jaundice	**Hematologic/Lymphatic**	
	Chest pain	**Pulmonary**			Bruising
	Palpitations		Cough		Enlarged lymph nodes
	Arm pain on exertion		Coughing up blood		Excessive bleeding
Genitourinary			Shortness of breath	**Other (please list any others)**	
	Prostate enlargement		Wheezing		
	Blood in urine	**Integumentary**			
	Change in urine appearance		Change in skin color		
	Urine incontinence		Rashes or itching		

Signature: It is extremely important that all medical information is disclosed to ensure your complete evaluation. I certify the information on this form is both accurate and complete to the best of my knowledge. No information has been withheld or omitted concerning my past and present state of health.

Signature of patient or guardian:	**Date:**

Form Last Updated: October 22 2020