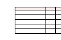
Patient name: ______________________

Patient History

Please answer every question.



STAFF: Handwritten responses must be entered **MANUALLY**.

PATIENT MEDICAL HISTORY

Please indicate if YOU have had any of the conditions listed below. Mark all that apply.

- AIDS
- Anemia
- Arthritis
- Anal fissure / tear
- Anesthesia problems
- Asthma
- Bipolar disorder
- Bleeding tendency
- Blood clots
- Bronchitis

Cancer

- Chemotherapy
- Radiation therapy
- Breast cancer
- Cervical cancer
- Colon cancer
- Esophageal cancer
- Kidney cancer
- Leukemia
- Lymphoma
- Lung cancer
- Mouth / throat cancer
- Ovarian cancer
- Pancreatic cancer
- Prostate cancer
- Rectal cancer
- Skin cancer
- Testicular cancer
- Uterine cancer
- Other cancer

- Congenital defects
- COPD
- Depression
- Diabetes
- Emphysema
- Endocrine disorder
- Epilepsy

Gastrointestinal

- Achalasia
- Barrett's esophagus
- **Bowel blockage**
  - small bowel
  - large bowel
  - do not know
- C. difficile colitis
- Celiac disease / sprue
- Chronic abdominal pain
- Chronic constipation
- Chronic diarrhea
- Cirrhosis
- Colon polyps
- Crohn's disease
- Diverticulitis
- Diverticulosis
- Esophageal narrowing / stricture
- Gallbladder problems
- Gastrointestinal bleeding
- GERD
- Hemorrhoids
- Hiatal hernia
- History of H. pylori
- Irritable bowel syndrome (IBS)
- Jaundice / yellow skin
- Liver disease
- Pancreatitis
- Ulcerative colitis
- Ulcer disease

- Glaucoma
- Gout

Heart

- Atrial fibrillation
- Congenital heart disease
- Congestive heart failure
- **Heart chest pain / angina**
  - with stents
  - bypass surgery
- High blood pressure
- High cholesterol
- High triglycerides
- Implantable defibrillator
- **MI (heart attack)**
  - with stents
  - bypass surgery
- Mitral valve prolapse
- Pacemaker
- Pathway ablation
- Valvular heart disease

- Headaches
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Hernia(s)
- HIV
- Infectious mono
- Kidney disease
- Migraines
- Osteoporosis
- Osteopenia
- Polio
- Polycystic ovarian disease
- Psychiatric disorder
- Seizures (date of last seizure): ______________________
- Sickle cell anemia
- Sickle cell trait
- **Sleep apnea**
  - with BIPAP
  - with CPAP
- Stroke
- Suicide attempt(s)
- Thyroid disease
- Venereal disease
- Other (please specify): ______________________ ______________________
- **NO PERTINENT MEDICAL HISTORY**

SURGERIES

Please indicate if YOU have had any of the surgeries listed below. Mark all that apply.

- **I HAVE HAD NO SURGERIES**
- Adenoids
- Appendix
- Arthroscopy
- Bowel resection
- Breast biopsy

Cataract surgery
- left
- right
- both

- Cystocele repair
- Gallbladder
- Heart bypass
- Heart transplant

Hysterectomy
- complete
- partial

Inguinal hernia repair
- left
- right
- both

Joint replacement

Hip
- left
- right
- both

Knee
- left
- right
- both

- Kidney stent
- Kidney stone removal
- Liver biopsy
- Lumpectomy
- Ovary removal
- Prostate biopsy
- Rectal prolapse repair
- Rectocele repair
- Tonsillectomy
- Weight reduction surgery
- Other surgery (please specify): ______________________ ______________________

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Patient name: ______________________________

Patient History

Please answer every question.

STAFF: Handwritten responses must be entered **MANUALLY**.

PROCEDURES

Please indicate if YOU have had any of the following.

YES	NO		Date (approximate) & findings:
◯	◯	Colonoscopy	
◯	◯	Flexible sigmoidoscopy	
◯	◯	Upper endoscopy	
◯	◯	ERCP (endoscopic retrograde cholangiopancreatography)	
◯	◯	EUS (endoscopic ultrasound)	
◯	◯	Ultrasound of abdomen or GI tract (past 6 months)	
◯	◯	CT scan of abdomen or GI tract (past 6 months)	
◯	◯	MRI of abdomen	

SOCIAL HISTORY

TOBACCO USE

Smoking status:	current (some days) ◯			former ◯
	current (every day) ◯			never smoked ◯
Packs daily:	<1 ◯	1 ◯	1 ½ ◯	2+ ◯
How long (in years)**:**	<5 ◯	5-9 ◯	10-19 ◯	20+ ◯
When stopped (years ago)**:**	<1 ◯	1-5 ◯	6-15 ◯	16+ ◯
Chewing tobacco:	yes ◯	no ◯	former ◯	never ◯
Cans per week:	<1 ◯	1 ◯	1 ½ ◯	2+ ◯
How long (in years)**:**	<5 ◯	5-9 ◯	10-19 ◯	20+ ◯
When stopped (years ago)**:**	<1 ◯	1-5 ◯	6-15 ◯	16+ ◯
Exposure to passive (second hand) **smoke:**		yes, outdoors only ◯	yes ◯	no ◯

ALCOHOL USE

Do you drink alcohol?	yes ◯	no ◯	former ◯	never ◯
Amount per week (number of drinks)**:**	occasional ◯	1-7 ◯	8-14 ◯	15+ ◯
When stopped (years ago)**:**	<1 ◯	1-5 ◯	6-15 ◯	16+ ◯

CAFFEINE

Coffee:	yes ◯	no ◯	former ◯	never ◯
Cups per day (8oz = 1 cup)**:**	<1 ◯	1 ◯	1 ½ ◯	2+ ◯
Other caffeine sources (tea, cola, high energy drinks, chocolate)**:**		yes ◯	no ◯	former ◯

DRUG USE

Do you use recreational drugs?	yes ◯	no ◯	former ◯	never ◯

Type(s): ______________________________

Frequency:	occasionally ◯	daily ◯	weekly ◯	monthly ◯

When stopped: ________________________

Do you have any tattoos?	yes ◯	no ◯
Do you have any body piercings?	yes ◯	no ◯
Have you ever had a blood transfusion?	yes ◯	no ◯

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Patient name: ____________________

Patient History

Please answer every question.

STAFF: Handwritten responses must be entered **MANUALLY**.

FAMILY MEDICAL HISTORY

Please indicate if YOUR FAMILY has a history of the following.

◯ **FAMILY HISTORY UNKNOWN** ◯ **ADOPTED** ◯ **NO SIGNIFICANT FAMILY HISTORY**

Please indicate which family member(s) have had these illnesses.	Father	Mother	Brother	Sister	Grandparents
Alcohol abuse	◯	◯	◯	◯	◯
Bleeding disorder	◯	◯	◯	◯	◯
Cancer, breast	◯	◯	◯	◯	◯
Cancer, esophageal	◯	◯	◯	◯	◯
Cancer, liver	◯	◯	◯	◯	◯
Cancer, ovarian		◯		◯	◯
Cancer, prostate	◯		◯		◯
Cancer, stomach	◯	◯	◯	◯	◯
Cancer, thyroid	◯	◯	◯	◯	◯
Cancer, uterine		◯		◯	◯
Celiac disease / sprue	◯	◯	◯	◯	◯
Chronic abdominal pain	◯	◯	◯	◯	◯
Cirrhosis	◯	◯	◯	◯	◯
Crohn's disease	◯	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯	◯
Gallstones	◯	◯	◯	◯	◯
Heart attack	◯	◯	◯	◯	◯
Hemochromatosis	◯	◯	◯	◯	◯
Hypertension (high blood pressure)	◯	◯	◯	◯	◯
Liver disease	◯	◯	◯	◯	◯
Pancreatitis	◯	◯	◯	◯	◯
Reflux	◯	◯	◯	◯	◯
Stroke	◯	◯	◯	◯	◯
Ulcerative colitis	◯	◯	◯	◯	◯

OTHER ◯ (Please specify illness and family member): ____________________

Have any of your blood relatives had **Colorectal Cancer?**

	Yes	No	Age relative developed condition, if known: 20's	30's	40's	50's	60's	70's	80+
Mother	◯	◯	◯	◯	◯	◯	◯	◯	◯
Father	◯	◯	◯	◯	◯	◯	◯	◯	◯
Sister	◯	◯	◯	◯	◯	◯	◯	◯	◯
Brother	◯	◯	◯	◯	◯	◯	◯	◯	◯
Daughter	◯	◯	◯	◯	◯	◯	◯	◯	◯
Son	◯	◯	◯	◯	◯	◯	◯	◯	◯

Have any of your blood relatives had **Colon Polyps?**

	Yes	No	Age relative developed condition, if known: 20's	30's	40's	50's	60's	70's	80+
Mother	◯	◯	◯	◯	◯	◯	◯	◯	◯
Father	◯	◯	◯	◯	◯	◯	◯	◯	◯
Sister	◯	◯	◯	◯	◯	◯	◯	◯	◯
Brother	◯	◯	◯	◯	◯	◯	◯	◯	◯
Daughter	◯	◯	◯	◯	◯	◯	◯	◯	◯
Son	◯	◯	◯	◯	◯	◯	◯	◯	◯

(U.S. Patent No. 7,487,102) (U.S. Patent No. 7,941,328)

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