



<input type="checkbox"/> No Diagnostic History		Diagnostic Procedure History	
<input type="checkbox"/> Abdominal/Pelvic Cat Scan	Month/Year:	<input type="checkbox"/> MRI - Abdominal	Month/Year:
<input type="checkbox"/> Abdominal/Pelvic Ultrasound	Month/Year:	<input type="checkbox"/> MRCP - Abdominal	Month/Year:
<input type="checkbox"/> Barium Enema	Month/Year:	<input type="checkbox"/> Sigmoidoscopy	Month/Year:
<input type="checkbox"/> Colonoscopy	Month/Year:	<input type="checkbox"/> Upper Endoscopy (EGD)	Month/Year:
<input type="checkbox"/> ERCP (endoscopic evaluation of the bile ducts)	Month/Year:	<input type="checkbox"/> Virtual Colonoscopy/CT	Month/Year:

<input type="checkbox"/> No Family History		Family History (Blood Relative)	
<input type="checkbox"/> Family History Unknown			
Colon Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relation:
Colon Polyps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relation:
Crohn's Disease Ulcerative Colitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relation:
Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relation:
Gallbladder Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relation:
Celiac Disease (gluten intolerance)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relation:
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Problem List / Medical History: Please check all that pertain to yourself			
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Home Oxygen	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anemia	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gastric or duodenal ulcer	<input type="checkbox"/> Liver disease or hepatitis	<input type="checkbox"/> Stroke or CVA
<input type="checkbox"/> Asthma	<input type="checkbox"/> H.Pylori infection	<input type="checkbox"/> Lung disease/breathing difficulties	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Cancer Type:	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Ulcerative colitis or Crohn's
<input type="checkbox"/> Colon or rectal polyps	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Pacemaker/Defibrillator	
<input type="checkbox"/> Depression	<input type="checkbox"/> Heart valve replacement	<input type="checkbox"/> Pancreatitis	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Reflux Esophagitis/Barrett's	

Social History					
<b>Occupation:</b>					
<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					
<b>Alcohol</b>	<input type="checkbox"/> None <input type="checkbox"/> Recovering Alcoholic				
	<input type="checkbox"/> Yes    Drinks per week: _____	<input type="checkbox"/> Beer	<input type="checkbox"/> Wine	<input type="checkbox"/> Liquor	How often: <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/> Social
<b>Tobacco</b>	Do you use Tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Quit Year _____	
	If yes, please select type of Tobacco use.	<input type="checkbox"/> Cigarettes _____ # per day	<input type="checkbox"/> Chew _____ # per day	<input type="checkbox"/> Pipe _____ # per day	<input type="checkbox"/> Cigars _____ # per day
<b>Drugs</b>	Do you currently use recreational or street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	If yes, please list type of drug _____ How often? _____				
	Have you ever given yourself non-prescribed drugs with a needle? <input type="checkbox"/> Yes <input type="checkbox"/> No				

## Surgical History

<input type="checkbox"/> NO SURGICAL HISTORY		<input type="checkbox"/> Hernia Repair	Month/Year:
<input type="checkbox"/> Abdominal	Month/Year:	<input type="checkbox"/> Hysterectomy	Month/Year:
<input type="checkbox"/> Appendectomy	Month/Year:	<input type="checkbox"/> Ileostomy	Month/Year:
<input type="checkbox"/> Colectomy	Month/Year:	<input type="checkbox"/> Laparoscopy	Month/Year:
<input type="checkbox"/> Colon Resection	Month/Year:	<input type="checkbox"/> Liver	Month/Year:
<input type="checkbox"/> Gallbladder	Month/Year:	<input type="checkbox"/> Lung	Month/Year:
<input type="checkbox"/> Gastric Band	Month/Year:	<input type="checkbox"/> Pancreatic	Month/Year:
<input type="checkbox"/> Gastric Bypass	Month/Year:	<input type="checkbox"/> Reflux	Month/Year:
<input type="checkbox"/> Heart	Month/Year:	<input type="checkbox"/> Ulcer	Month/Year:

### Changes in health in the past year (Please check only those items which apply)

<b>GENERAL</b>	<b>CARDIOVASCULAR</b>	<input type="checkbox"/> Decreased Appetite	<b>HEME/LYMPH</b>
<input type="checkbox"/> Weight Loss ____lbs	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Anemia
<input type="checkbox"/> Weight Gain ____lbs	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Difficulty in Swallowing	<input type="checkbox"/> Easy/Increased Bruising
<input type="checkbox"/> Fevers	<input type="checkbox"/> Abnormal Swelling legs/feet	<input type="checkbox"/> Gas	<input type="checkbox"/> Enlarged/Swollen Glands
<input type="checkbox"/> Chronic Fatigue	<b>RESPIRATORY</b>	<input type="checkbox"/> Heartburn	<b>MUSCULOSKELETAL</b>
<b>SKIN</b>	<input type="checkbox"/> Trouble Breathing	<input type="checkbox"/> Leakage of Stool	<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Skin Rashes	<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Milk/Dairy Intolerance	Pain <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Joints
<input type="checkbox"/> Jaundice (yellow skin or eyes)	<input type="checkbox"/> Coughing up Blood	<input type="checkbox"/> Mucus in stool	Stiffness <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Joints
<b>EAR-NOSE-THROAT</b>	<input type="checkbox"/> Coughing up Sputum	<input type="checkbox"/> Nausea	<b>NEUROLOGICAL</b>
<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Asthma	<input type="checkbox"/> Rectal Pain	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Headaches
<input type="checkbox"/> Sore Throat	<b>GASTROINTESTINAL</b>	<input type="checkbox"/> Vomiting of Blood	<input type="checkbox"/> Migraines
<b>EYES</b>	<input type="checkbox"/> Abdominal Pain	<b>ENDOCRINE</b>	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Black Stools	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Seizures
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Bloating	<input type="checkbox"/> Excessive Urination	<b>PSYCHOLOGICAL</b>
	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Intolerance to Cold	<input type="checkbox"/> Anxiety
	<input type="checkbox"/> Constipation	<input type="checkbox"/> Intolerance to Heat	<input type="checkbox"/> Depression
	<input type="checkbox"/> Cramps		

Thank you for your time. This information will assist us to help you. Remember to bring this form to your appointment. Please feel free to call if you have questions.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_