MEDICAL HISTORY

Patient _____ Date _____

Family Physician _____ DOB _____/_____/_____ Age _____

PERSONAL MEDICAL HISTORY (You, the patient)

AIDS	Deafness	History of ovarian cancer
Anemia	Depression	History of peptic ulcer
Anxiety Disorder	Diabetes mellitus	History of prostate cancer
Artificial Heart Valve	Dialysis	History of renal insufficiency
Arthritis, degenerative/rheumatoid	Diarrhea	History of skin cancer
Angina pectoris (chest pain)	Diverticulitis	History of stroke/TIA
Angioplasty/Stent	Diverticulosis	History of uterine cancer
Blood Clots in Legs	Fatty Liver Disease	High cholesterol
CABG	GERD	High blood pressure
History of heart attack	Gout	Hypothyroidism
Atrial fibrillation	Hemorrhoids	Irritable bowel syndrome
Barrett's esophagus	Hepatitis B/C	Mitral insufficiency
Bipolar disorder	History of bladder cancer	Pancreatic cyst
Cardiac defibrillator/pacemaker	History of breast cancer	Parkinson's disease
Gall bladder problems	History of cervical cancer	Post Traumatic Stress Disorder
Pancreatitis	History of colonic polyps	Seizure Disorder
Cirrhosis	History of Colon Cancer	Schizophrenia
Constipation	History of kidney cancer	Sinus disease
Congestive heart failure	History of leukemia	Sleep apnea
COPD, Asthma	History of lung cancer	Thyroid disorder
COPD, bronchitis	History of lymphoma	Ulcerative colitis
COPD, emphysema	History of mental retardation	Wheelchair Bound
Crohn's disease		

Current MEDICATIONS (List dose and frequency). Please include **over-the-counter** medications.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medication and contact allergies: Write None if you have no allergies

List ALLERGIES to medications & contact allergies (ie: Latex) and what reaction you have to them.

_____

_____

_____

Family history COLON CANCER (list relative: brother, mother, etc)_____

Family history other cancers (list relative and type, if known)_____

Family history heart disease High blood pressure Diabetes Liver disease

Social History

Do you currently smoke?_____ Cigarettes/Cigars Packs/day _____ How long? _____

If not, have you ever smoked?_____ For how long?_____ When did you quit? _____

Do you chew tobacco? _____ Dip snuff? _____

Do you use recreational drugs?_____ Which one? _____How often? _____

Have you used recreational drugs in the past?_____ When did you quit? _____

Do you drink alcohol? _____ What type? _____

How much and how often? _____

What is your occupation? _____ Are you currently working? _____

Are you retired? _____ Disabled? _____

Marital status _____ Number of children _____

Living Arrangements: family friend alone assisted living nursing home

Previous SURGERIES (circle and indicate approximate year)

Appendectomy
Gallbladder Removed
Colon Resection
Ulcer surgery
Bowel obstruction
Cardiac Bypass Surgery
Skin lesion removal
Tubal ligation
Bladder surgery
Hemorrhoidectomy
Cardiac Valve Replacement
Abdominal Wall Hernia Repair

Anal fissure repair
Back surgery
Umbilical hernia repair
Hiatal hernia repair
Ileostomy
Inguinal hernia repair
Abdominal aneurysm
Lung/Chest surgery
Breast surgery
Prostate surgery
Vascular Surgery
Neck surgery

Orthopedic-foot/leg surgery
Specify:_____

Orthopedic-arm/hand surgery
Specify:_____

Ear/Nose/Throat surgery
Specify:_____

Hysterectomy
Ovaries removed: yes or no

List Other Surgeries:

Previous GI PROCEDURES done elsewhere (indicate date and location)

Upper endoscopy
Esophageal dilation
Colonoscopy

Liver biopsy
Barium enema
Flexible sigmoidoscopy

Upper GI series
CT scan
Ultrasound