

# PATIENT HISTORY

Date \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Maiden \_\_\_\_\_

SSN \_\_\_\_\_ Race \_\_\_\_\_ Sex M F Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number (s) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Referred by \_\_\_\_\_

**Do you have an Advanced Directive/Living Will?** No / Yes, please provide a copy prior to your procedure.

**Purpose of this visit?** \_\_\_\_\_

**Allergies** No / Yes, list \_\_\_\_\_

**Any previous reaction to Anesthesia?** No / Yes, describe \_\_\_\_\_

**Current Medications & Dosages** (Please list or bring bottles to your visit) \_\_\_\_\_

**Previous Surgeries & Dates** (check & date all that apply)

___ NONE _____	___ Colon _____	___ Gallbladder _____
___ Hysterectomy _____	___ Appendix _____	___ Cataracts _____
___ Stomach _____	___ Other (please list and date below) _____	___ Lens implant _____
_____	_____	_____
_____	_____	_____

**Recent Hospitalizations** (past year) No / Yes, explain \_\_\_\_\_

**FAMILY HISTORY** (check all that apply & list family member(s) affected)

___ Colon Cancer _____	___ Colon polyps _____
___ Colitis _____	___ Stomach Cancer _____
___ Pancreatic cancer _____	___ Liver disease _____
___ Breast Cancer _____	___ Heart disease _____
___ Diabetes _____	___ Other _____

**Social History**

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital status \_\_\_Single \_\_\_Married \_\_\_Widowed \_\_\_Divorced \_\_\_Separated

Alcohol No / Yes, amount \_\_\_\_\_ Tobacco No / Yes, amount \_\_\_\_\_

IV or intranasal drugs No / Yes, \_\_\_\_\_ Tattoos No / Yes Body Piercing No / Yes

**Nutrition**

Height \_\_\_\_\_ft \_\_\_\_\_inches Weight \_\_\_\_\_ lbs. Weight loss \_\_\_\_\_ lbs. Weight gain \_\_\_\_\_ lbs.

Special Diet \_\_\_\_\_ Food Allergies \_\_\_\_\_

**PAST MEDICAL HISTORY (CIRCLE ALL THAT APPLY NOW OR IN THE PAST)**

**HEENT**

Glaucoma  
Cataracts  
Sinus problems  
Seasonal allergies  
Hoarseness  
Sore throat  
Legally blind  
Deaf

**Musculoskeletal**

Arthritis  
Rheumatoid arthritis  
Sjogren's syndrome  
Lupus  
Fibromyalgia  
Back pain

**Psychiatric**

Depression  
Anxiety  
Stress related symptoms  
Nervousness  
Post traumatic stress disorder  
Other \_\_\_\_\_

**Cardiovascular**

Chest pain  
Heart Attack  
High blood pressure  
High cholesterol or triglycerides  
Irregular heart beat  
Congestive heart failure  
Swelling of legs  
Artificial Heart Valve  
Pacemaker

**Gastrointestinal**

Nausea  
Vomiting  
Vomiting blood  
Swallowing problems  
Heartburn  
Abdominal pain  
Abdominal bloating  
Ulcers  
Constipation  
Diarrhea  
Rectal bleeding  
Black tarry stool  
Gallstones  
Liver disease  
Hepatitis  
Pancreatitis  
Colon polyps  
Colon cancer  
Stomach cancer

**Genitourinary**

Frequent urination  
Painful urination  
Prostate problems  
Bladder infections  
Kidney disease  
Kidney infections  
Kidney stones  
Dialysis

**Respiratory**

Wheezing  
Shortness of breath  
Cough  
Asthma  
Emphysema  
COPD

**Neurological**

Headaches  
Migraines  
Dizziness  
Fainting  
Seizures  
Stroke

**Heme/Onc/Infectious Disease**

HIV  
Hepatitis B or C  
Anemia  
Clotting disorder  
Blood transfusion(s), year \_\_\_\_\_  
Cancer \_\_\_\_\_

**Endocrine**

Diabetes  
Thyroid disease  
Osteoporosis

Do you use any of the following? \_\_\_\_\_ wheelchair \_\_\_\_\_ walker \_\_\_\_\_ cane \_\_\_\_\_ assistance with walking

Last Menstrual Period \_\_\_\_\_

Last Colonoscopy \_\_\_\_\_ Last Upper Endoscopy \_\_\_\_\_

Notes \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Completed by \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date reviewed \_\_\_\_\_