

PATIENT HISTORY

Date _____

Last Name _____ First _____ MI _____ Maiden Name _____

SSN _____ Race _____ Male/Female _____ Date of Birth ____/____/____ Age _____

Address _____ City _____ State _____ Zip _____

Home # (____) _____ Cell/Alt # (____) _____ Work # (____) _____

Emergency Contact /Relationship _____ Phone (____) _____

Primary Care Physician _____ Referred by _____

Occupation _____ Employer _____

Do you have an Advanced Directive? _____ YES _____ NO If yes, please provide a copy.

What is the purpose of your visit? _____

Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	Student Status: <input type="checkbox"/> N/A <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time	Children: <input type="checkbox"/> YES <input type="checkbox"/> How many? <input type="checkbox"/> NO	Height: _____ ft. _____ inches Weight: _____ lbs. Weight Loss: _____ lbs. Weight Gain: _____ lbs.		
Special diet _____		Food Allergies _____			
	YES	NO		YES	NO
Tobacco Use How Much?			Tattoos		
Alcohol Use How Much?			Body Piercing		
Recreational/Street Drugs How Much?			Any previous reaction to anesthesia?		
What pharmacy do you use? Please include location and telephone number.			Are you allergic to any medicines? (please list)		

PRESENT MEDICATIONS: Include any over-the-counter, herbal and vitamins.

Please provide dose and frequency; if unsure bring bottles.

PAST SURGICAL HISTORY: NONE _____

Surgery	Date	Surgery	Date	Surgery	Date
Tonsillectomy		Gallbladder		Stomach	
Hysterectomy		Appendix		Colon	
Cataracts		Lens Implant		Heart	
Mastectomy R/L		Other:		Other:	

FAMILY HISTORY: Have any of **your family members** ever had any of the following (mother, father, brother, sister, grandparents)

	YES	NO	
Colitis			
Colon Polyps			
Colon Cancer			
Stomach Cancer			
Pancreatic Cancer			
Breast Cancer			
Esophageal Cancer			
Liver Disease			
High Blood Pressure			
Heart Disease			
Diabetes			

Physician Notes _____

Name _____

PRESENT MEDICAL HISTORY: Are you currently having or recently had any of the following symptoms:

GASTROINTESTINAL	YES	NO	HEENT	YES	NO	NEUROLOGICAL	YES	NO
Painful/Difficulty Swallowing			Chronic Sore Throat			Dizziness		
GERD/Heartburn			Hoarseness			Fainting		
Indigestion			Legally Blind			Headache		
Nausea			Deaf			ENDOCRINE		
Vomiting			RESPIRATORY			Diabetes		
Black Stools			Cough			Thyroid Disease		
Fluid in the Abdomen			Shortness of Breath			MUSCULOSKELETAL		
Liver Disease			Wheezing/Asthma/COPD			Joint Pain		
Jaundice			Sleep Apnea/CPAP			Swelling		
Hepatitis B			Home Oxygen			Back Pain		
Hepatitis C			CARDIOVASCULAR			Neck Pain		
HIV			Chest Pain			Lumbar Pain		
Change in Bowels			Angina			PSYCHIATRIC		
Rectal Bleeding			Artificial Heart Valve			Depression		
Hemorrhoids			Pacemaker			Anxiety/Stress		
Diarrhea			Defib Guidant/Medtronic			HEMATOLOGY		
Constipation			Heart Irregularity			Anemia		
Incontinence			Swelling of Lower Extremities			Easy Bruising		
Painful Stools			High Cholesterol			SKIN		
Drainage Around Rectum			GENITOURINARY			Rash		
Gastric Ulcer			Urgency/Burning/Frequency			Lesion		
Colon Polyps			Frequency			DO YOU USE OR NEED		
Crohns Disease			Prostate Problems			Assistance with walking		
Ulcerative Colitis			Kidney Failure/Disease			Assistance with standing		
Abnormal Liver Function			Dialysis			Wheelchair		
Abdominal Pain Where?						Walker/Cane		

PAST MEDICAL HISTORY: Have YOU ever had any of the following?

GASTROINTESTINAL	YES	NO	HEENT	YES	NO	NEUROLOGICAL	YES	NO
Gastric Ulcer			Glaucoma			Seizures		
Colon Polyps			Blindness			Stroke		
Crohns Disease			Cataracts			ENDOCRINE		
Ulcerative Colitis			Migraines			Diabetes		
CARDIOVASCULAR			Seasonal Allergies			Hypothyroidism		
Heart Attack			Bleeding from Nose			Hyperthyroidism		
Heart Irregularity			Chronic Sore Throat			GENITOURINARY		
High Blood Pressure			RESPIRATORY			Kidney Stone		
Congestive Heart Failure			Asthma			Calcium Abnormality		
Artificial Heart Valve			Shortness of Breath			Prostate Problems		
Abnormal Heart Valve			COPD			Renal Failure/Disease		
CANCER			Tuberculosis			SKIN DISEASE		
Breast Cancer			MUSCULOSKELETAL			PSYCHIATRIC		
Uterine Cancer			Osteoporosis			Psychiatric Disorders		
Ovarian Cancer			Osteoarthritis			Anxiety/Stress		
Cervical Cancer			Scleroderma			HEMATOLOGY		
Other:			Fibromyalgia			Anemia		

Last Colonoscopy _____

Last Upper Endoscopy _____

LMP (first day of your last menstrual period) _____

Completed by _____ Reviewed by _____ Date _____