GENERAL HISTORY-PLEASE FILL IN AND MAIL TO OFFICE WITH THE PATIENT INFO SHEET

Patient Name: ______________________________ DOB ________________ Date __________________

1. **Allergies to medications?** ☐ Yes ☐ No If yes, please list allergy and what the reaction is (ex: rash, hives, etc.)

____

2. **Are you currently taking:** □Aspirin □Coumadin □Plavix □Lovenox □ Pletal □Aggrenox □Effient □Pradaxa □Ticlid □Xarelto
   Which Physician prescribed any of the medication you check on question #2. Dr. ________________________

3. **Medication(s) (Prescription & over the counter)** ____

   ____

4. **Past Medical History:**

Colon Cancer ☐ Yes ☐ No	Colon Polyps ☐ Yes ☐ No	Esophageal Cancer ☐ Yes ☐ No
Barrett's Esophagus ☐ Yes ☐ No	GE Reflux (GERD) .☐ Yes ☐ No	GI Peptic Ulcer ☐ Yes ☐ No
GI Duodenal Ulcer ☐ Yes ☐ No	GI Jejunal Ulcer ☐ Yes ☐ No	IBD ☐ Yes ☐ No
Crohn's Disease ☐ Yes ☐ No	IBS ☐ Yes ☐ No	Liver Cancer ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No	Rectal Cancer ☐ Yes ☐ No	Stomach Cancer ☐ Yes ☐ No
Viral Hepatitis ☐ Yes ☐ No	Arthritis ☐ Yes ☐ No	CAD ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No	Hyperlipidemia ☐ Yes ☐ No	Hypertension .☐ Yes ☐ No
Pulmonary Disease ☐ Yes ☐ No	Ulcerative Colitis? ☐ Yes ☐ No	History of strokes? ☐ Yes ☐ No

Renal or kidney disease? ☐ Yes ☐ No Wheelchair restricted? ☐ Yes ☐ No Are you on oxygen? ☐ Yes ☐ No

Heart Disease (heart attack, heart failure)? ☐ Yes ☐ No History of other Cancer? ☐ Yes, site______________ ☐ No

Do you have an AICD (Automated Internal Cardiac Defibrillator) ☐ Yes ☐ No Pacemaker? ☐ Yes ☐ No BOTH? □

When was the last time your pacemaker was checked? ______________________________

5. **Surgical History/Organ Transplants (including dates):** ______________________________________

   ____

6. **Family History:**

   Do you have a family history of Colon Polyps? ☐Yes ☐ No If yes, which family member? ______________

   Do you have a family history of Colon Cancer? ☐Yes ☐ No If yes, which family member? ______________

7. **Social history:**

   Do you smoke? __________ Type? ________ How many packs a day? _______ For how many years? __________

   Do you drink alcohol? _________ How many drinks per day? ________ Per week? __________ Per month? ___________

PLEASE FILL IN OTHER SIDE ➔➔➔➔

OFFICE USE ONLY

PROCEDURE: COLON / EGD / OTHER ____________ OV:____________ DATE: ________________________
FACILITY: HMC / HSC TIME: ________________________
PHYSICIAN: DJL / RMS / SPH / RDH / NG/ MJK DIAGNOSIS: ______________________________________
LABS: ____
ANTIBIOTICS: ________________________________ PREP:__________ RECEIVED ON: __________

Patient Name:____ Birth Date:_______________________

Patient reported: Height- ________ ft ________in Weight- ________________lbs

Review of Systems- please put an "x" in all that apply. I have no current symptoms_______________________

CONSTITUTIONAL	YES	EYES	YES	GASTROINTESTINAL	YES	ENDOCRINE	YES
Fever		Blindness		Heartburn		Cold Intolerance	
Chills		Blurred Vision		Dysphagia (difficulty swallowing)		Heat Intolerance	
Weight gain		Double Vision		Nausea		Polydipsia (Excessive Thirst)	
Weight Loss		CARDIOVASCULAR		Abdominal Pain		Polyphagia (Excessive Hunger)	
Fatigue/malaise		Chest Pain		Diarrhea		HEME/ LYMPHATIC	
Night Sweats		Dyspnea on Exertion (Shortness of Breath with Exertion)		Constipation		Swollen Nodes	
Weakness		Heart Palpitations		Blood in Stool		Abnormal bleeding	
Decreased Appetite		Orthopnea (Difficulty breathing when lying flat)		GENITOURINARY		Increased Bruising	
SKIN		Claudication (pain in legs when walking)		Urinary Incontinence		NEUROLOGICAL	
Rash		Leg Swelling		Dysuria (Pain with Urination)		Amaurosis Fugax (Vision Loss in one eye)	
Itching		Rest Pain (in Legs)		Urinary Urgency		Numbness/Tingling	
Skin Lesion		Ulcerations on Skin		Urinary Frequency		Seizures	
HENT		Cold Extremities		Hematuria (Blood in urine)		Dizziness	
Headaches		Skin color Changes		Impotence		Lightheadedness	
Hearing Loss		Irregularity of Heart Rhythm		RESPIRATORY		Speech Changes	
Tinnitus (ringing in the ears)		Cyanosis (Bluish color of the skin)		Apnea		Focal Weakness	
Nosebleeds		MUSCULOSKELETAL		Shortness of breath		Parathesias (Leg/Arm Weakness)	
Sore Throat		Myalgias (Muscle Pain)		Wheezing		Tremor	
Sinus Pain		Back Pain		Snoring		Sensory Change	
		Joint Pain		Cough		PSYCHIATRIC	
		Falls		Hemoptysis (blood in Sputum/Phlegm)		Memory Loss	
		GI SYMPTOMS		Sputum Production		Depression	
		Jaundice (yellowing of the skin or eyes)				Nervous/Anxious	
		Black stools				Insomnia	
		Vomiting					
		Vomiting of Blood					
		Bright Red Blood per Rectum					

Other Symptoms:

____

PREFERRED PHARMACY____