PAST MEDICAL HISTORY

	YES		YES		YES		YES
	❑	Congestive Heart Failure	❑	GERD - reflux	❑	Osteoporosis	❑
Anal Cancer	❑	Chronic Airway Obstruction	❑	GI Bleed	❑	Ovarian Cancer	❑
Anemia	❑	Cirrhosis	❑	Heart Attack (MI)	❑	Prostate Cancer	❑
		Colon/Rectal Cancer	❑	Hepatitis	❑	Pulmonary Embolus	❑
Anxiety	❑	Connective Tissue Disorder	❑	High Cholesterol.	❑		
Arthritis	❑	Constipation	❑	HIV	❑	Radiation Treatment	❑
Asthma	❑	Crohn's Disease	❑	Hypertension	❑	Seizure Disorder	❑
Atrial Fibrillation	❑	DVT – blood clots	❑	Irritable Bowel Disease	❑	Sleep Apnea	❑
Autoimmune Disease	❑	Dementia	❑	Kidney Disease/CRF	❑	Stroke	❑
Bleeding/Clotting Disorder	❑	Depression	❑	Kidney Stone	❑	Thyroid Problems	❑
Breast Cancer	❑	Diabetes	❑	Liver Disease	❑	Transplant _____	❑
BPH – enlarged prostate	❑	Diverticulitis	❑	Lung Cancer	❑	Ulcerative Colitis	❑
CAD	❑	Diverticulosis	❑	Mental Disorder	❑	Urinary Tract Infection	❑
Cancer _____	❑	Emphysema	❑	MRSA Infection	❑	Venereal Disease	❑
C-Difficile Colitis	❑	Endometriosis	❑	Obesity	❑		

PAST SURGICAL HISTORY

	YES		YES		YES		YES
	❑	Carotid Endarterectomy	❑	Hernia Repair	❑	Pilonidal Surgery	❑
Abdominoplasty	❑	Colectomy- Total	❑	Hip Replacement	❑	Prostatectomy	❑
Lysis of Adhesions	❑	Colectomy- Partial	❑	Knee Replacement	❑	Prostate Seeds	❑
Amputation _____	❑			Inguinal Hernia Repair	❑		
Anal Fissure	❑	Cholecystectomy-Gallbladder	❑	Laparotomy	❑	Small Bowel Resection	❑
Anal Fistula	❑	Colonoscopy	❑	Mastectomy R__ L__	❑	Spinal Surgery	❑
Appendectomy	❑		❑	Nephrectomy R__ L__	❑	Splenectomy	❑
Back Surgery	❑	Colostomy	❑			Thoracotomy	❑
Breast Surgery	❑	Colostomy Revision	❑	Ovary Removal	❑	Thyroidectomy	❑
CABG – heart bypass	❑	Cystocele/Rectocele Repair	❑			Tonsillectomy	❑
Cardiac Cath	❑			Pacemaker	❑	Tubal Ligation	❑
Cardiac Cath w/Stent	❑			Parathyroidectomy	❑	TURP	❑
	❑	Hemorrhoidectomy	❑			Valve Replacement	❑
						Vascular Stent	❑
						Anesthesia Problem	❑
						Post Op Delirium	❑

NAME:_____ **DOB:**_____

REVIEW OF SYSTEMS

Do you currently have?

GENERAL:	YES
Decreased Appetite	❑
Fever	❑
Chills	❑
Weight Gain	❑
Weight Loss	❑
Fatigue	❑
Weakness	❑

EYE:	YES
Blurry Vision	❑
Double Vision	❑
Eye Pain	❑

EAR/NOSE/THROAT:	YES
Hearing Loss	❑
Ear Ringing	❑
Sore Throat	❑
Hoarseness	❑

CARDIAC:	YES
Chest Pain	❑
Palpitations	❑
Fainting	❑
Edema	❑

RESPIRATORY:	YES
Shortness of Breath	❑
Cough	❑
Wheezing	❑
Coughing Blood	❑

GASTROINTESTINAL:	YES
Abdominal Pain	❑
Heartburn/Difficulty Swallowing	❑
Change in Bowel Habits	❑
Rectal Bleeding	❑
Nausea	❑
Vomiting	❑

GENITOURINARY:	YES
Urinary Incontinence	❑
Urinary Frequency	❑
Bloody Urine	❑
Nighttime Urination	❑
Burning with Urination	❑

ENDOCRINE:	YES
Hair Loss	❑
Muscle Weakness	❑
Cold Intolerance	❑

MUSCULOSKELETAL:	YES
Neck Pain	❑
Back Pain	❑
Joint Pain	❑
Joint Swelling	❑
Arthritis	❑

HEMATOLOGIC:	YES
Easy Bruising	❑
Easy Bleeding	❑
Enlarged Lymph Nodes	❑
Anemia	❑

DERMATOLOGIC:	YES
New Skin Lesions	❑
Changing Moles	❑
Rash	❑
Hives	❑

PSYCH/NEURO:	YES
Depression	❑
Anxiety	❑
Confusion	❑
Sleep Disturbance	❑
Memory Loss	❑
Headaches	❑

NAME:_____

DOB:_____

GENERAL HISTORY

Last Colonoscopy _____

Height _____

Weight _____

SOCIAL HISTORY

Marital status _____

Smoking Status:
- Current Every Day Smoker _____
- Current Some Day Smoker _____
- Former Smoker _____
- Never a Smoker _____

Cigars/ Chew: _____
Alcohol Use: _____
Drug Use: _____
Caffeine: _____

FAMILY HISTORY

Do any family members have:	List family member
Breast Cancer	_____
Colon Cancer	_____
Crohn's Disease	_____
Heart Disease	_____
Heart Disease	_____
Ovarian Cancer	_____
Prostate Cancer	_____
Colitis	_____
Uterine Cancer	_____

FEMALE ONLY:

Pregnancies: _____
Children _____
Vaginal: _____
C-Section _____

Last Mammogram _____

Last Period _____
Age of First Period ____
Age of Menopause ____

Occupation: _____

Recent Travel _____

List all Medications with dose, include over the counter:

_____

_____

_____

_____

_____

_____

Drug Allergies:

_____

_____

_____

Pharmacy Information:

Name: _____

Location: _____

Phone: _____

NAME: _____

DOB: _____