PATIENT NAME: ______________________ AGE ______ DATE ______

REASON FOR THIS VISIT: ______________________

Have you had any of the following? *Please mark the appropriate box with an "X":*

	YES	NO
Nausea		
Vomiting		
Diarrhea		
Constipation		
Number of bowel movements per day:		
Rectal pain or bleeding		
Recent change in bowel habits		
Loss of weight		
Loss of appetite		
Belching		
Heartburn/regurgitation		
Trouble swallowing/pain on swallowing		
Black, tarry stools		
Abdominal pain		
Jaundice		
Chest pain		
Shortness of breath		
Palpitations		
Chronic cough		
Urinary difficulty		
Frequent urination		
Blood in Urine		

	YES	NO
Abnormal vaginal bleeding		
Vaginal discharge or infection		
Gastrointestinal cancers		
Colon Polyps		
Ulcer		
Hepatic/Liver Disease		
Crohn's Disease or Ulcerative Colitis		
Celiac Disease		
Pancreatitis		
Recent cardiac/heart problems		

Please explain: ______________________

	YES	NO
High blood pressure		
Lung problem		
Diabetes mellitus		
Elevated cholesterol		
Stroke		
Thyroid		
Arthritis		
Kidney problems		

Please list any additional problems or injuries you have had: ______________________

Please list any past surgical problems and describe any operations you have had: ______________________

	Operations	Year	Hospital
1.			
2.			
3.			

Last Mammogram ________ Last PAP ________ Last Bone Density ________

Have you had an anesthesia reaction or bleeding tendencies? YES NO If so, when and please describe: ______________________

Have you had previous gastroscopy? YES NO If so, when and where, and what were the results? ______________________

Have you had previous colonoscopy? YES NO If so, when and where, and what were the results? ______________________

OVER

Cat Scan?	YES	NO	Sonogram?	YES	NO
Upper GI Series?	YES	NO	Barium Enema?	YES	NO

Please list any drugs you are allergic to: ☐ NONE

1.__________ 2.__________ 3.__________ 4.__________

Please list all medications you have been on during the last year:

Drug (include aspirin)	Dosage	For how long?	Reason for taking this drug

Do you have tatoos?	YES	NO	If yes, where?	
Do you have piercings (other than ear)?	YES	NO	If yes, where?	
Do you smoke?	YES	NO	If yes, how many?	
Do you drink alcohol?	YES	NO	If yes, how often?	
Have you had blood transfusions?	YES	NO	If yes, when?	

Does anyone in your family have any of the following? *Please mark the appropriate box with an "X" and indicate which family member (father, mother, sibling, children, etc.:*

	YES	NO
Cancer (if yes, what organ?)		
Colon Polyps		
Liver Disease/Hepatitis		

	YES	NO
Crohn's Disease/Ulcerative Colitis		
Celiac Disease/Sprue		
Diabetes		
Heart Disease		
Stroke		
Elevated Cholesterol		
Thyroid Disease		

PLEASE USE THE SPACE BELOW FOR ANY ADDITIONAL INFORMATION OR COMMENTS WHICH YOU FEEL MIGHT BE OF INTEREST:

Patient Signature: __________ Date: __________

MD Signature: __________ Date: __________

MD Comments: