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MEDICAL HISTORY

NAME: _____ **DATE:** _____ **D.O.B.:** _____ **SEX: M or F**

REASON FOR VISIT: _____

ARE YOU HERE FOR A COLONOSCOPY SCREENING? YES or NO

LAST COLONOSCOPY: _____ **LAST UPPER ENDOSCOPY:** _____

SURGICAL HISTORY

_____

_____

_____

_____

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS
ASTHMA	☐	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐	☐
HYPERTENSION	☐	☐	☐	☐	☐
CANCER	☐	☐	☐	☐	☐
COLON CANCER/POLYP	☐	☐	☐	☐	☐
STOMACH/ULCER	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐

DRUG ALLERGIES

_____

_____

_____

_____

WOMEN ONLY: Pregnant? Yes or No

Last Menstrual Period: _____

Hysterectomy? Yes Year _____

Do you have an advanced directive/ living will? YES NO (please circle)

MEDICAL HISTORY: please check all that is applicable

☐ Allergies/Hay Fever	☐ Colon Polyps	☐Asthma	☐ Heart Disease	☐ Fatigue	☐ Alcoholism
☐ High Cholesterol	☐ High Blood Pressure	☐ MI	☐ Chest Pain	☐ COPD	☐ Ulcers
☐ Difficulty Swallowing	☐ Blood in Stool	☐ Anemia	☐ Diabetes	☐ HIV	☐ Hepatitis
☐ Liver Disease	☐ Abdominal Pain	☐ Gallbladder Disease	☐ History of Seizures	☐ Heartburn	

HABITS:

☐ Smoke: Packs per day_____ ☐Coffee/Caffeine: Cups/Glasses per day _____ ☐ Contact with blood/bodily fluids at work
How Long? _____ ☐ Alcohol: Type: _____ Quantity: _____

CURRENT MEDICATIONS: Please list ALL medications that you are taking.

MEDICATION	STRENGTH	FREQUENCY	MEDICATION	STRENGTH	FREQUENCY