Name: _____ **Date of Birth** _____
(Please include any *former* names you may be listed under)

Medical History: Please circle or highlight below any conditions that you have been diagnosed with.

Hepatitis C | Hepatitis B | Cirrhosis | Other liver condition:
Pre-cancerous (adenomatous) colon polyps | Ulcerative Colitis | Crohn's Disease | Irritable Bowel Syndrome (IBS)
GERD (reflux) | Barrett's Esophagus | Pancreatitis | Bowel Obstruction | Celiac Disease | Stomach or small bowel ulcer
Have you had a prior endoscopy elsewhere? (e.g. Colonoscopy, EGD, ERCP, etc). Please provide dates/location/details: Other gastrointestinal conditions you have already been diagnosed with:
History of any of the following cancers: Colon or rectal | Esophagus | Lung | Breast | Prostate | Skin | Thyroid | Other/details:
High blood pressure | High Cholesterol | Coronary Artery Disease | Heart attack | Heart Failure (CHF) | Endocarditis
Atrial fibrillation | Pacemaker or Defibrillator | Stents | Other heart or vascular condition/details:
Anemia | Blood clotting problem | Other blood condition/details:
Asthma | COPD | Sleep apnea | Use a CPAP machine | Use oxygen | Other lung condition:
Diabetes | Thyroid Condition | Kidney Condition | Adrenal insufficiency | Other kidney or endocrine problem:
Stroke | Pre-stroke/TIA | Migraines | Multiple Sclerosis | Seizure Disorder | Major memory or brain problem | Dementia
Dizziness or Balance problem, please specify: | Other brain or neurologic problem:
Arthritis | Rheumatoid Arthritis | Fibromyalgia | Other bone/joint/rheumatology condition:
Hearing Loss | Glaucoma | Macular Degeneration | Other eye or ear condition:
Depression | Anxiety Disorder | Bipolar | Schizophrenia | PTSD | Physical abuse | Sexual abuse | Other:
Other medical history that we should know about you or further details of any of the above:

Month/Year	Please list SURGERIES you have had (including hysterectomy, heart bypass, gallbladder surgery, etc).

MEDICATION	Dosage (e.g. mg/ pill)	How often taken?

DRUG ALLERGIES: It is important we be made aware of ANY drug reactions you have experienced. **[ ]** ***I have no known drug allergies***	
MEDICATION	**REACTION**
Do you have an allergy to latex? [ ] Yes [ ] No	

Smoking history:

[ ] Current, every day [ ] Former smoker (quit _____)
[ ] Current, some days [ ] Never smoked
If yes, please check [ ] cigarettes [ ] cigars [ ] pipe [ ] chew
When did you start?_____ How much do you smoke? _____

Do you drink alcohol? [ ] Yes [ ] No _____ servings per *day / week / month / year* (1 serving = 2 oz of liquor = 1 glass of wine = 1 beer) Quit: _____ Prior use: _____	Have you ever used illicit drugs? What are you currently using?	Are you working? What do you do?

Family History: Please tell us about medical problems in your family. In particular, does anyone in your family have a history of the below? Please tell us who, age diagnosed, and any other known information.
Indicate if you were adopted; include any details about your biologic relatives.

Anyone in the family with colon or rectal cancer? [ ] Yes [ ] No
If yes, who? _____

Anyone with: **colon polyps, Ulcerative Colitis, Crohn's, Liver disease, or any other conditions of the esophagus, intestine, gallbladder, liver or pancreas?**

Please bubble "Y" for "yes" to any symptoms you are <u>currently</u> experiencing;

Gastrointestinal	Y	N
abdominal pain	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
rectal bleeding	○	○
blood in stool	○	○
heartburn	○	○
regurgitation	○	○
difficulty swallowing	○	○
nausea	○	○
vomiting	○	○

Cardiovascular	Y	N
chest pain	○	○

Respiratory	Y	N
shortness of breath	○	○

Constitutional	Y	N
weight loss more than 5 lbs	○	○
weight gain	○	○
loss of appetite	○	○

Hematologic/Lymphatic	Y	N
bleeding disorder	○	○
clotting disorder	○	○
use of blood-thinning medications besides aspirin	○	○
significant bleeding after a medical procedure	○	○

Allergic/Immunologic	Y	N
unexplained fever	○	○
exposure to or at risk for tuberculosis	○	○

Musculoskeletal	Y	N
joint pain	○	○
trouble walking	○	○

Endocrine	Y	N
heat intolerance	○	○

Genitourinary	Y	N
painful urination	○	○
urinary incontinence	○	○
pregnant or trying to get pregnant	○	○
breastfeeding	○	○
heavy periods	○	○
irregular periods	○	○

Integumentary	Y	N
rashes	○	○

Neurological	Y	N
frequent headaches	○	○
numbness or tingling	○	○
memory loss	○	○
confusion	○	○
implanted device	○	○

Psychiatric	Y	N
sad or depressed feelings	○	○
anxiety attacks	○	○

Eyes	Y	N
significant vision loss or blindness	○	○

ENMT	Y	N
dizziness	○	○

○ **I have none of the above currently.**