



Date: _____

Last Name: _____

First Name: _____

Date of Birth: _____

Referring Doctor Name: _____

Primary Care Doctor's Name: _____

Reason for Visit:

- 1) Colon Cancer screening or Colonoscopy
- 2) Acid Reflux
- 3) Irritable Bowel Syndrome
- 4) Others: _____

Allergies:

| Medications | Reactions |
|-------------|-----------|
| | |
| | |
| | |

Preferred Pharmacy Name and Full Address: _____

Mail order Pharmacy Name and address: _____

Medications List:

| Medication | How often a day |
|------------|-----------------|
| | |
| | |
| | |
| | |
| | |
| | |

Chronic Problems:

Please indicate what medical conditions have or had and the approximate year of diagnosis:

Gastrointestinal:

- Irritable Bowel Syndrome
- History of Colon Polyps. If Yes, Last colonoscopy: _____
- Personal History of Colon Cancer
- Acid Reflux/GERD
- Hemorrhoids
- Gallstones
- Ulcers
- Pancreatitis
- Ulcerative Colitis
- Crohn's Disease
- Diverticulosis
- Small Bowel Obstruction

Liver disorders:

- Fatty Liver disease
- Hepatitis B
- Hepatitis C
- Cirrhosis
- Abnormal Liver tests/Enzymes

Cardiology:

- Heart Attack or CAD If yes, Last heart attack or Stent placement: _____
- Congestive Heart Failure
- Angina
- Arrhythmias or Atrial Fibrillation or Atrial Flutter
- Blood thinner use
- Heart Valve replacement
- Pacemaker
- Defibrillator or AICD placement

Pulmonary:

- COPD
- Sleep Apnea
- Requiring CPAP
- Asthma
- Pulmonary Embolism
- Others: _____

Eyes:

- Glaucoma

Endocrine:

- Diabetes
- Thyroid problems
- Others: _____

Rheumatology:

- Rheumatoid Arthritis
- SLE or Lupus
- Osteoarthritis

Blood Disorders:

- Anemia
- Leukemia
- Clotting disorders

Neurological:

- Stroke/CVA
- TIA
- Seizures
- Parkinson's disease
- Multiple Sclerosis

Psychiatric:

- Depression
- Anxiety
- Bipolar disorder
- Schizophrenia

Surgical History:

Cholecystectomy or Gallbladder removal

Colonoscopy – If yes, when _____, Polyps removed _____

Endoscopy _____

Appendix removal

Colon resection

Bowel resection

Uterus removal or Hysterectomy

Cesarian section

Social History:

Smoking Cigarettes _____. If yes, How many packs a day _____, How Long _____

Alcohol use : amount frequency

- Beer _____ Per _____
- Wine _____ Per _____
- Spirits _____ Per _____
- Never _____

Drug use _____

Marijuana use _____

Electric cigarette use _____

Family History:

- Any family member with Colon Cancer?
- No known family history of colon Cancer
- No family history of colon polyps
- Immediate Family member with sudden death or major heart attack?

| | Father | Mother | Others _____ | _____ | _____ |
|--------------------|--------|--------|--------------|-------|-------|
| Colon Cancer | | | | | |
| Colon Polyps | | | | | |
| Celiac Disease | | | | | |
| Ulcerative Colitis | | | | | |
| Liver Disease | | | | | |
| Stomach cancer | | | | | |
| Esophagus cancer | | | | | |

Current Symptoms:

Have You Had Any of These Symptoms in the Last 6 Months? (Check any that apply)

| | | |
|---|---|--|
| Gastrointestinal <ul style="list-style-type: none">○ Abdominal pain○ Acid reflux○ Bloating or swelling○ Change in bowel habits○ Constipation○ Diarrhea○ Difficulty swallowing○ Fecal Incontinence | Cardiovascular <ul style="list-style-type: none">○ Chest pain○ Irregular heart beat○ Palpitations○ Swelling of your arms or legs○ Difficulty breathing while laying down | Respiratory <ul style="list-style-type: none">○ Asthma○ Cough○ Short of breath○ Wheezing |
| Constitutional <ul style="list-style-type: none">○ Fatigue○ Loss of appetite○ Weight loss○ Weight gain | Hematological <ul style="list-style-type: none">○ Bleeding gums○ Easy Bruising○ Prolonged bleeding | Neurological <ul style="list-style-type: none">○ Dizziness○ Migraine○ Seizures○ Tremors |

| | | |
|---|--|--|
| Psychiatric <ul style="list-style-type: none"> ○ Anxiety ○ Depression ○ Hallucinations ○ Panic attacks ○ PTSD ○ Paranoia | | |
|---|--|--|

Patient Signature: _____

Date: _____