# Patient Medical History

*Please complete this history form. This will allow us to serve your health needs. The information contained herein is strictly confidential and will not be released unless you authorize us to do so.*

**Marking Instructions**

- *Use a #2 Pencil.*
- *Mark all items that apply to you.*
- *Fill in the complete oval as shown . . .*

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

DIRECTION OF FEED

PLEASE PRINT PATIENT'S DATE OF BIRTH

Month Day Year

PATIENT'S SOCIAL SECURITY NUMBER

**I have received a copy of the HIPPA notice of privacy practices.** Yes ○

## PATIENT MEDICAL HISTORY

**Fill in the oval if you have had any of the conditions listed below, or fill in the "NONE" oval.**

**Gastrointestinal Conditions**

| | | |
|---|---|---|
| Barrett's Esophagus ○ | Hemorrhoids ○ | Gallstones ○ |
| Liver Failure/Cirrhosis ○ | Anal Fissure ○ | Pancreatitis ○ |
| Celiac Disease or Sprue ○ | Colon Polyps ○ | Diverticulitis ○ |
| Gastrointestinal Bleeding ○ | Diverticulosis ○ | Hepatitis A ○ |
| Irritable Bowel Syndrome ○ | Crohn's Disease ○ | Hepatitis B ○ |
| Stomach Ulcer or Duodenal Ulcer ○ | Colitis/Ulcerative ○ | Hepatitis C ○ |
| GERD/Esophagitis/Acid Heartburn ○ | Intestinal Infection ○ | Autoimmune ○ |
| Esophageal Stricture or Narrowing ○ | Bowel Obstruction ○ | Other ○ |
| History of Helicobacter Pylori Infection ○ | Other Liver Disease ○ | **NONE** ○ |

**Non-Gastrointestinal Conditions**

| | |
|---|---|
| Bleeding Disorder ○ | Lupus ○ |
| Multiple Sclerosis ○ | Stroke ○ |
| High Blood Pressure ○ | Asthma ○ |
| Emphysema or COPD ○ | Anemia ○ |
| Congestive Heart Failure ○ | Diabetes ○ |
| Hardening of the Arteries ○ | Blood Clots ○ |
| Atrial Fibrillation/Arrhythmia ○ | HIV Positive ○ |
| Treatment with Blood Thinner ○ | Fibromyalgia ○ |
| Coronary Artery Disease/Heart Attack ○ | Seizure Disorder ○ |
| Antibiotic Treatment Within Past 2 Months ○ | **NONE** ○ |

**Cancer**

| | | |
|---|---|---|
| Mouth/Throat ○ | Prostate ○ | Skin ○ |
| Esophagus ○ | Lungs ○ | Pancreas ○ |
| Stomach ○ | Breast ○ | Other ○ |
| Colon or Rectum ○ | Uterus ○ | **NONE** ○ |
| Blood (e.g. Leukemia) ○ | Ovaries ○ | |

## FAMILY HISTORY

**Have any of your blood relatives had colorectal cancer or polyps?** Yes ○ No ○

**If yes, at what age did your family member have colorectal cancer?**

| | 20's | 30's | 40's | 50's | 60's | 70's | 80+ |
|---|---|---|---|---|---|---|---|
| **Grandparent** | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **Parent** | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **Sibling** | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **Offspring** | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **Aunt/Uncle** | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**Other family history: Fill in the oval if a relative — parent, grandparent, sibling, offspring, aunt or uncle — has had one of the following.**

| | | |
|---|---|---|
| Breast Cancer ○ | Hepatitis B ○ | Gallstones ○ |
| Ovarian Cancer ○ | Hepatitis C ○ | Pancreatitis ○ |
| Uterine Cancer ○ | Ulcerative Colitis ○ | Liver Failure ○ |
| Stomach Cancer ○ | Bleeding Disorder ○ | Blood Clots ○ |
| Liver Cancer ○ | Hemachromatosis ○ | Celiac Disease ○ |
| Irritable Bowel Syndrome ○ | Autoimmune Hepatitis ○ | Crohn's Disease ○ |
| | | **NONE** ○ |

## PERSONAL AND SOCIAL HISTORY

| | |
|---|---|
| ○ married ○ single ○ divorced ○ widowed | **Marital Status:** |
| ○ never ○ in the past ○ currently | **Do you consume alcohol?** |
| ○ never ○ in the past ○ currently | **How would you describe your cigarette smoking?** |
| ○ never ○ occasionally ○ regularly | **How often do you consume caffeinated beverages?** |
| ○ yes ○ no | **Recent foreign travel?** |
| ○ never ○ in the past ○ currently ○ prefer to discuss with doctor | **Recreational drug use?** |

## *Symptoms & Other Conditions*

***Mark all that apply** - if no symptoms, please mark **"none"*** ***hx = history***

| | | | |
|---|---|---|---|
| ○ vomiting | ○ vomiting blood | ○ irregular bowel habits | **GASTROINTESTINAL** |
| ○ nausea | ○ painful swallowing | ○ incontinence of stool | |
| ○ jaundice | ○ gas/flatulence | ○ get full quickly at meals | |
| ○ diarrhea | ○ constipation | ○ fresh blood in stools | |
| ○ bloating | ○ black stools | ○ difficulty swallowing | |
| ○ belching | ○ abdominal pain | ○ abdominal distention | |
| ○ heartburn | | ○ **none** | |
| ○ chills/fever | ○ night sweats | ○ hx of IV drug use | **GENERAL** |
| ○ weight loss | ○ loss of appetite | ○ hx of IV blood transfusion | |
| ○ weight gain | ○ sleep disturbance | ○ feeling of excessive cold or warmth | |
| ○ fatigue | | ○ **none** | |
| ○ hx of stroke | ○ recent passing out | ○ convulsions or seizures | **NEUROLOGICAL** |
| ○ recent dizziness | ○ frequent headaches | ○ **none** | |
| ○ pacemaker | ○ automatic defibrillator | ○ irregular heart rate, palpitations | **CARDIOVASCULAR** |
| ○ coronary stents | ○ hx of heart murmur | ○ chest pain or pressure with exertion (angina) | |
| ○ leg swelling | | ○ chest pain or chest pressure after eating or when upset | |
| ○ high cholesterol or triglycerides | | ○ **none** | |
| ○ chronic cough | ○ wheezing | ○ shortness of breath | **RESPIRATORY** |
| ○ chronic or frequent hoarseness | | ○ exposure to tuberculosis | |
| | | ○ **none** | |
| ○ kidney stones | ○ incontinence | ○ difficulty urinating | **GENITOURINARY** |
| ○ kidney failure | ○ blood in urine | ○ frequent urinary infections | |
| | | ○ **none** | |
| ○ diabetes | ○ thyroid disease | ○ **none** | **ENDOCRINE** |
| ○ endometriosis | | ○ Are you or could you be pregnant? | **FEMALE** |
| ○ heavy menstrual periods | | ○ **none** | |
| ○ anxiety | ○ hx of mental illness | ○ hx of physical or sexual abuse | **PSYCHOSOCIAL** |
| ○ stress | ○ hx of depression | ○ hx of eating disorders | |
| | | ○ **none** | |
| ○ rash | ○ severe itching | ○ **none** | **SKIN** |
| ○ arthritis | ○ joint pain | ○ back pain | **BONE & JOINT** |
| | | ○ **none** | |
| ○ anemia | ○ excessive bleeding | ○ enlarging or painful lymph nodes | **BLOOD** |
| ○ easy bruising | | ○ **none** | |

| | | | |
|---|---|---|---|
| ○ Brain | ○ Back/Spinal | ○ Adhesion | SURGERIES |
| ○ Colon | ○ Esophagus | ○ Aortic Aneurysm | **Please mark all surgeries that you have had.** |
| ○ Prostate | ○ Gallbladder | ○ Appendix Removal | |
| ○ Stomach | ○ Heart Bypass | ○ Joint Replacement | |
| ○ Transplant | ○ Heart Valve | ○ Uterine/Ovarian | |
| ○ Ulcer | | ○ Weight Loss | |

| | | | |
|---|---|---|---|
| ○ Medication | ○ Latex/Rubber | ○ Food | ALLERGIES |
| ○ Soy, Nuts, or Eggs | ○ Anaphylactic or other reaction to anesthesia | | |

# Intake Questionnaire

**Name:**_____ **Date:**_____

**D.O.B.:**_____ **Email Address:**_____

**Reason for Visit:**_____

**Current Medications and Dosage:**

| MEDICATION NAME/ OTC | DOSE | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Drug Allergies:**

_____

**Referring Physician:**_____

**PLEASE PROVIDE YOUR PHARMACY INFORMATION SO WE KNOW WHERE TO SEND ANY MEDICATIONS YOU MAY BE PRESCIBED**

****Top Section Only****

**E-Rx Form**

**Name:_____Medicare Pt: Y/N**

**DOB:_____**

**Pharmacy Name:_____**

**Pharmacy Address:_____**

**Pharmacy Phone Number:_____**

**Rx :**

- ☐ **Suprep**
- ☐ **Linzess 145/290**
- ☐ **Omeprazole 40**
- ☐ **Amitiza 8mcg/24mcg**
- ☐ **Clenpiq**

**Refills: 1 2 3 PRN**

**Physician_____**

**Give to Sara/CC to be entered into the E-Rx system.**

****Please mark superbill E-Rx****