Name:_____ DOB:_____ Height:_____ Weight:_____

What is the reason for your visit? _____

How long have you had concerns?_____

Review of Systems: Please Circle Yes or No

Chills	Y / N	Fecal Incontinence	Y / N	Light-headed	Y / N
Fever	Y / N	Nausea	Y / N	Weakness	Y / N
Fatigue	Y / N	Protrusion/Swelling	Y / N	Anxiety	Y / N
Weight Loss	Y / N	Rectal Bleeding	Y / N	Depression	Y / N
Hearing Changes	Y / N	Vomiting	Y / N	Mood Changes	Y / N
Nasal Congestion	Y / N	Burning with Urination	Y / N	Contact Allergy	Y / N
Sore Throat	Y / N	Frequent Urination	Y / N	Hives	Y / N
Visual Changes	Y / N	Inability to Urinate	Y / N	Pruritus	Y / N
Cough	Y / N	Urinating at night	Y / N	Skin Rash	Y / N
Shortness of breath	Y / N	Breast Lumps	Y / N	Back Pain	Y / N
Wheezing	Y / N	Breast Pain	Y / N	Joint Swelling	Y / N
Chest Pain	Y / N	Vaginal Discharge	Y / N	Joint Pain	Y / N
Leg Swelling	Y / N	Sexual Dysfunction	Y / N	Anemia	Y / N
Palpitations	Y / N	Penile Discharge	Y / N	Easy Bleeding	Y / N
Abdominal Pain	Y / N	Cold Intolerance	Y / N	Easy Bruising	Y / N
Blood in stool	Y / N	Excessive Thirst	Y / N	Swollen Glands	Y / N
Change in bowel habits	Y / N	Heat Intolerance	Y / N	Asthma	Y / N
Constipation	Y / N	Gynecomastia	Y / N	Chemicals in Work Place	Y / N
Diarrhea	Y / N	Dizziness	Y / N	Immunosuppression	Y / N
Rectal Discharge	Y / N	Headache	Y / N		

Have you ever been treated for the following:

Chlamydia	Y / N
Syphilis	Y / N
HIV	Y / N
Herpes	Y / N
Gonorrhea	Y / N
HPV	Y / N

Do you have a pacemaker? Y / N
If so, what model is it?_____
When was it placed?_____

Do you have Sleep Apnea? Y / N
Do you use a CPAP/BiPAP Machine? Y / N
What is the setting?_____

Do you need to take antibiotics before any surgical or dental procedure? Y / N **Do you have Glaucoma? Y / N**

Have you ever had a Colonoscopy? Y / N If so, when/where/by whom? _____

Have you ever had a Flexible Sigmoidoscopy? Y / N If so, where/where/by whom?

How often do you move your bowels?_____

Allergies:

_____
_____
_____
_____
_____
_____

Surgical History/ Operations

_____
_____
_____
_____
_____
_____

Current Medications (including herbs & vitamins)

Name	Dose	Frequency	Prescriber

Name:_____ DOB:_____

Patient Medical History ☐ If none, Please check this box.

Alcoholism	Y / N		Hepatitis	Y / N	
Anemia	Y / N	If so, what type? _____	Hyperlipidema	Y / N	If so, what type? _____
Arthritis	Y / N		Hypertension	Y / N	
Asthma	Y / N		Irriable Bowel Syndrome	Y / N	
Blood Transfusion	Y / N	If so, when? _____	Kidney/Renal Disease	Y / N	
Celiac Disease	Y / N		Kidney Stones	Y / N	
Cholelithiasis	Y / N		Liver Cancer	Y / N	If so, when? _____
Chronic Renal Failure	Y / N		Liver Disease	Y / N	
Cirrhosis	Y / N	If so, what type? _____	Migraine Headaches	Y / N	
Colon Cancer	Y / N	If so, when? _____	Obesity	Y / N	
Colon Polyps	Y / N		Osteoporosis/Osteopenia	Y / N	
Congestive Heart Failure	Y / N		Pancreatitis	Y / N	
COPD	Y / N		Parkinson's Disease	Y / N	
Coronary Artery Disease	Y / N		Peptic Ulcer Disease	Y / N	If so, when? _____
Crohn's Disease	Y / N		Prostate Cancer	Y / N	
Cerebrovascular Accident (Stroke)	Y / N		Prostate Hyperplasia, Benign	Y / N	
Diabetes Mellitus	Y / N	If so, what type? _____	Seizure Disorder	Y / N	
Diverticular Disease	Y / N		Thyroid Disease	Y / N	
Exposure to Hepatitis	Y / N	If so, when? _____	Ulcerative Colitis	Y / N	
GERD (Reflux)	Y / N		Varices - Esophageal	Y / N	
Gout	Y / N		Varices - Gastric	Y / N	
Hemochromatosis - Hereditary	Y / N				

Family Medical History

Diagnosis:	Y / N	If Yes, what member?	Diagnosis:	Y / N	If Yes, what member?
Alcoholism	Y / N	_____	Diverticular Disease	Y / N	_____
Alzheimer's Disease	Y / N	_____	Gallbladder Disease	Y / N	_____
Asthma	Y / N	_____	Hyperlipidema	Y / N	_____
Blood Disorders	Y / N	_____	Hypertension	Y / N	_____
Coronary Artery Disease	Y / N	_____	Irriable Bowel Syndrome	Y / N	_____
Cancer	Y / N	_____	Liver Disease	Y / N	_____
If Yes, What Type _____			Migraine Headaches	Y / N	_____
Celiac Disease	Y / N	_____	Obesity	Y / N	_____
Colitis	Y / N	_____	Osteoporosis/Osteopenia	Y / N	_____
Colon Cancer	Y / N	_____	Peptic Ulcer Disease	Y / N	_____
Colon Polyps	Y / N	_____	Kidney/Renal Disease	Y / N	_____
Crohn's Disease	Y / N	_____	Rheumatoid Arthritis	Y / N	_____
Cerebrovascular Accident (Stroke)	Y / N	_____	Seizure Disorder	Y / N	_____
Diabetes Mellitus	Y / N	_____	Ulcerative Colitis		_____
If Yes, What Type_____			Other:		_____
					_____

Social History

Tobacco Smoking Status Y / N Formerly Type of Tobacco_____

Alcohol Drinks Alcohol? Y / N Formerly Type_____ Frequency_____
Amount_____ Last Drink_____

Caffeine Y / N Type_____ Caffeine Per Day_____

Religious/Spiritual

Do you agree to Blood Transfusion if medically necessary? Y / N

Patient Signature:_____ Date:_____