Name: ______________________________ DOB: ________________

Reason for Appointment: (Please be specific)

____

____

Have you ever received a pneumonia vaccine? NO YES

Social History:

Do you smoke tobacco? NO YES **If yes, how often?** ________________

Have you ever smoked? NO YES **If yes, when did you quit?** ________________

Other tobacco products? NO YES **If yes, type and how much?** ________________

Do you drink alcohol? NO YES **Beer, wine or liquor? How many a week?** ________________

Medication Information:

Are you currently taking or have you recently discontinued (in the last 2 weeks) any immunosuppressant medications, such as Methotrexate, Prednisone, and Humira? NO YES Type: ________________

Are you on any blood thinners? NO YES

If so which one? Aspirin Warfarin (Coumadin) Pradaxa Eliquis Xarelto

Plavix (Clopidogrel) Prasugrel Brilinta Cilostazol Aggrenox other: ________________

What pharmacy do you use? ______________________ **Location:** ________________

MEDICATIONS: Please list ALL of your medications including over-the-counter meds or provide a list

1	11
2	12
3	13
4	14
5	15
6	16
7	17
8	18
9	19
10	20

Drug Allergies and Reactions:

Drug	*Reaction*	*Drug*	*Reaction*
1		6	
2		7	
3		8	
4		9	
5		10	

Medical History:

Primary Care Doctor: ____________________________ **Gynecologist:** ________________________________

Cardiologist: ___________________________________ **Urologist:** ___________________________________

Pulmonologist: _________________________________ **Oncologist:** __________________________________

Have you ever had a colonoscopy? NO YES
If so, Date: __________ **Where:** ______________________ **Doctor's Name:** _____________________

Have you ever had a flexible sigmoidoscopy? NO YES
If so, Date: __________ **Where:** ______________________ **Doctor's Name:** _____________________

Past Medical History: Check which ones **YOU** have been diagnosed with (all that apply)

Anxiety	Heart Attack
Arthritis (specify)	Heart Disease
Asthma	Hepatitis
Bipolar Disorder	HIV (AIDS)
Bleeding Disorder (specify)	High Blood Pressure
Blood Clots (where)	Irregular Heart Beat (specify)
BPH	Kidney Disease
Cancer (specify)	Reflux/ Heart Burn
CDIFF	Sleep Apnea
Colon or Rectal Cancer	Stroke
Colon Polyps	STD (specify)
COPD	Ulcerative Colitis
Crohn's Disease	Chronic UTIs
Depression	OTHER:
Diabetes	
Diverticulitis	
Diverticulosis	

Past Surgical History: (Please list **ALL** surgery procedures or provide list)

Family History: (Mother, Father, Brother, Sister, Son, Daughter)

Has anyone in your family ever had colon or rectal cancer? If so, who? ______________________

Has anyone in your family ever had colon polyps? If so, who? ______________________

Any other health problems in immediate family? If so, what and who? ______________________

____

Review of Systems: (Circle ALL that apply)

General: Fever Chills Weight Loss Weight Gain Fatigue/Weakness Other: ____________

Skin: Rash Sores Other: ____________

Head/Neck: Headache Swollen Glands Other: ____________

Lungs/Heart: Cough Wheezing Shortness of Breath Chest Pain Palpitations Other: ____________

Urinary: Frequency Pain with Urination Other: ____________

Musculoskeletal: Muscle or Joint Pain Other: ____________

Neurological: Fainting Numbness Tremors Other: ____________

Hematologic: Easy Bruising/Bleeding History of Clotting Problems Other: ____________

Gastrointestinal: Anorectal bleeding Anorectal pain Anorectal itching/burning
Nausea Constipation Diarrhea Change in stool size Vomiting
Change in bowel habits Fecal incontinence Blood in stool Heart burn
Abdominal pain – lower left – lower right – upper left – upper right Other: ____________

Printed Patient Name: ____

Social Security Number: ______________________________ DOB: ____________________

Email: ____

(This is needed for any procedures or tests that may have to be scheduled with outside facilities.)

Below, please list any family members, friend, or other person that you give us permission to speak with concerning your healthcare. Doctors do not need to be included. If none apply, please write: None.

Name	Relationship	Phone Number

Do you have an advanced directive? NO YES

If yes, please provide our office a copy.

If no, would you like us to provide you with one? ____________