MEDICAL HISTORY

Please mark any condition that you have had.

☐ High Blood Pressure	☐ Esophageal Stricture	☐ Kidney Disease
☐ Heart Disease	☐ Barrett's Esophagus	☐ Kidney Stones
☐ Congestive Heart Failure	☐ Ulcers	☐ BPH or Prostate Enlargement
☐ Heart Murmur	☐ Crohn's Disease	☐ Prostate Cancer
☐ Peripheral Vascular Disease	☐ Ulcerative Colitis	☐ Osteoporosis
☐ Varicose veins	☐ Diverticulosis	☐ Degenerative Disk Disease
☐ COPD	☐ Colon Polyps	☐ Arthritis
☐ Emphysema	☐ Colon Cancer	☐ Stroke
☐ Asthma	☐ Gallbladder Disease	☐ Mini-stroke or TIA
☐ Tuberculosis	☐ Hepatitis (A) (B) (C)	☐ Seizures
☐ Sleep Apnea	☐ Cirrhosis	☐ HIV or AIDS
☐ Tobacco Abuse	☐ Pancreatitis	☐
☐ Lung Cancer	☐ Diabetes	☐
☐ Reflux or GERD	☐ Thyroid Disease	☐

SURGICAL HISTORY

Please mark any procedure that you have had.

☐ Appendectomy	☐ Gallbladder Surgery	☐ Removal of Skin Cancer
☐ Back Surgery	☐ Heart Bypass	☐ Repair of Broken Bone
☐ Breast Surgery	☐ Heart Valve Replacement	☐ Prostate Surgery
☐ Carotid Surgery	☐ Hernia Repair	☐ Tonsillectomy
☐ Colon Surgery	☐ Hysterectomy	☐ Thyroid Surgery
☐ Colonoscopy	☐ Joint Replacement	☐
☐ EGD	☐ Lung Surgery	☐
☐ Eye Surgery	☐ Neck Surgery	☐

FAMILY HISTORY

Please mark any conditions that any of your <u>blood relatives</u> have had.

☐ Heart Disease	☐ Colon Cancer	☐ Diabetes
☐ High Blood Pressure	☐ Esophageal Cancer	☐ Epilepsy
☐ Tuberculosis	☐ Stomach Cancer	☐ Kidney Disease
☐ Lung Disease	☐ Other Cancers	☐ Blood Disease
☐ Asthma	☐ Colon Polyps	☐ Mental Disease
☐ Breast Cancer	☐ Reflux	☐ Problems with Anesthesia

SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes ☐ Quit - When? _____ How many packs per day? _____ For how many years? _____

Do you drink alcohol? ☐ No ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily Type? _____

Do you use or have you used illicit or street drugs like cocaine, crack, meth, heroin, LSD, or marijuana? ☐ No ☐ Yes ☐ Quit

ALLERGIES

Please list any medication allergies and describe the reaction

Medication	Reaction
Medication	Reaction
Medication	Reaction
Medication	Reaction
Medication	Reaction

MEDICATIONS

Please list any medications that you are currently taking (including over-the-counter meds)

Medication	Dosage	Frequency	As needed?
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

VITAMINS AND HERBAL SUPPLEMENTS

Medication	Dosage	Frequency	As needed?
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

IMMUNIZATIONS

Please list date of last immunization

Tetanus _____	Pneumonia _____	Influenza _____	Hepatitis _____

OTHER INFORMATION

Please use the space below for any other information that you think we need to know about.

REVIEW OF SYSTEMS

Please mark any symptom that you have had.

General	☐ Jaundice, liver disease or abnormal liver tests
☐ Change in weight _____ lbs. during last 6 months	☐ Pancreatitis
☐ Difficulty sleeping	☐ Hemorrhoids
☐ Fever	**Genitourinary**
☐ Night sweats or chills	☐ Frequent urination
Head, Eyes, Ears, Nose, Throat	☐ Difficulty starting or stopping urine
☐ Headaches or migraines	☐ Burning or painful urination
☐ Light headed or dizziness	☐ Blood in urine
☐ Blurred vision	☐ Urinating at night (# of times a night _____)
☐ Other change in vision	☐ Recurrent urinary tract infections
☐ Dry eyes	☐ Kidney stones
☐ Glaucoma	☐ Hx of STDs (Syphilis, Gonorrhea, Herpes, Genital Warts)
☐ Loss of hearing	**Musculoskeletal**
☐ Ringing in ears	☐ Joint pain or swelling
☐ Nose bleeds	☐ Arthritis
☐ Sinus problems	☐ Fibromyalgia
☐ Hoarseness	☐ Osteoporosis or osteopenia
Cardiovascular	☐ Back or neck problems
☐ Chest pain	**Neurologic/Psychiatric**
☐ Irregular heartbeat	☐ Stroke, Mini-stroke or TIA
☐ High blood pressure	☐ Blackouts or loss of consciousness
☐ Heart murmur	☐ Numbness or tingling in fingers, hands, or feet
☐ Angina or heart attack	☐ Seizures
☐ Heart stents	☐ Depression
☐ Poor circulation	☐ History of suicide attempt
☐ Leg swelling or varicose veins	**Hematologic**
Respiratory	☐ Anemia
☐ Shortness of breath	☐ Blood transfusion
☐ Difficulty breathing	☐ Blood clots or DVTs
☐ Difficulty breathing lying down	☐ Free bleeder or difficulty getting bleeding to stop
☐ Persistent cough	**Skin**
☐ Coughing up blood	☐ Easy bruising
☐ Wheezing or asthma	☐ New moles or change in mole
☐ Sleep apnea (Use CPAP yes / no)	☐ Breast lump or nipple discharge
Gastrointestinal	☐ Bad scar formation
☐ Abdominal pain or cramps	**Endocrine**
☐ Bloating after meals	☐ Diabetes
☐ Heartburn or reflux	☐ Thyroid problems
☐ Difficulty swallowing	☐ Excessive thirst
☐ Diarrhea	☐ Change in tolerance to heat or cold
☐ Constipation	**Women only**
☐ Change in bowel habits or diameter of stool	☐ Abnormal periods or bleeding
☐ Nausea or vomiting	☐ Vaginal discharge
☐ Vomiting blood	**Men only**
☐ Black or tarry stools	☐ Penile discharge
☐ Blood in stool or on toilet paper	☐ Impotence or erectile dysfunction

Please use this page for any extra space that you need to answer questions or for information that you think that we need to know about.

 Name _____