MEDICAL HISTORY FORM (please print and use BLACK ink only)

Patient Name: ____Date of Birth: ____________Age:_______

Please fill out this form completely (we cannot accept attached lists) and to the best of your ability. All questions are a necessary part of your consultation and the answers are confidential.

Reason for Visit: _____________________________________Date of Visit: _________________________

PERSONAL HEALTH HISTORY: Height__________ Weight__________

(Please check all that apply)

_____Diabetes ___Insulin ___Diabetic Oral Meds ___Diet Controlled, average am blood sugar: ______

_____Migraines _____Headaches _____Stroke _____Mini Stroke/ TIA _____Seizures (last one :_______)

_____Glaucoma _____Eye Problems _____Wear Contacts

_____Anxiety _____ Depression _____Psychiatric Disorder

_____Asthma _____COPD _____Pneumonia _____Tuberculosis _____Thyroid Disease

_____High blood Pressure _____Heart Disease

___Chest Pain _________Murmur/when ___Heart Attack ___Stents ___Irregular Heartbeat

___Congestive Heart Failure ___Pacemaker ___ Defibrillator ___Mitral Valve Prolapse

_____Sleep Apnea _____Use a BIPAP/CPAP

Do you snore loudly, louder than talking, or loud enough to be heard through closed doors? Y N

Do you often feel tired, fatigued or sleepy during the daytime? Y N

Has anyone observed you stop breathing during your sleep? Y N

_____Liver Disorder _____Hepatitis – type _____

_____Bladder Problems _____Kidney Stone _____Kidney Disease _____Kidney Failure/Dialysis

_____Prostate Disorder _____BPH

_____Arthritis _____Neuropathy _____Vascular Disorder _____Weakness/Numbness Arms and/or legs

_____Fibromyalgia _____Chronic Pain _____Back Pain_____ Limited Neck Movement _____TMJ

_____ Have Dentures _____Wear Hearing Aides

_____Cancer (type: _______________________) Treatment: ___Surgery ___Chemo ___Radiation

_____Anemia _____Blood Clots _____Blood Disorders_____ Blood Transfusion _____Bleeding Disorder

_____Skin Disorders _____Ever had MRSA _____ CDiff _____HIV/AIDS _____Other:_________________

Are you followed by a Cardiologist or other Specialist? Y N Name______________ Last Visit________

LIFESTYLE INFORMATION:

Do you currently smoke Y N: _____cigarettes _____cigars _____pipe if so, how much: ___________

How long have you smoked? __________________________

Former Smoker Y N Date Quit: __________ Have you smoked 100 cigarettes in your lifetime Y N

Are you in danger of second hand smoke Y N Do you use smokeless tobacco Y N

Do you become short of breath with walking or climbing stairs Y N

Do you drink alcohol regularly Y N How much? ____________ Daily _________ Weekly_________

Do you drink Coffee Y N, cups per day _____ Tea Y N, cups per day _____

Caffeinated Soda Y N , cans or bottles per day _____

Do you use street/recreational drugs Y N Type _________________ How Often _______________

Orally_________ Nasal__________ Intravenous__________

Have you ever used street/recreational drugs Y N Type: __________________________

Do you have tattoos Y N Professionally Done Y N Homemade Y N

Do you have a cold or sinus infection at present or recently Y N

Are you on a special or restricted diet? Y N Type: _________________________

Do you use _____cane _____walker _____crutches _____ wheelchair

Do you have frequent falls or loss of balance Y N

Please list all Medications (including over the counter and herbal medications – *we cannot accept an attached list*)

Clearly Spell Medication:	DOSE:	Frequency :

Patient Name ____ D/O/B ___________________

Allergies To Medicines:	Reaction:

Allergy to _____ Latex _____Adhesive Tape _____Shellfish _____IV Contrast Dye _____Foods

_____Any Problems with Anesthesia _____Any Family History of Anesthesia Problems? Describe:

____

List All Operations and/or Hospitalizations:

Approximate Date:	Diagnosis and/or Operation:	Hospital:	Doctor:

FEMALE PATIENTS:

Are you pregnant ___Y ___N ___Maybe Date of last menstrual period ______________________

Age of 1st period _______ Age of Menopause ______Number of pregnancies ___Miscarriages _______

History of heavy menstrual flow? Y N History of Endometriosis? Y N

FAMILY HISTORY:

	Age	Please List Any Serious Illnesses	Age at Death/Cause
Father			
Mother			
Sisters			
Brothers			
Children Son or Daughter			
Son or Daughter			
Son or Daughter			

Patient Name ______________________________________ D/O/B ________________

Has anyone in your family been diagnosed with the following:

	Yes	No	Relationship	Age at diagnosis
Colon Cancer				
Colon Polyps				
Crohns Disease				
Ulcerative Colitis				
Irritable Bowel Syndrome				
Celiac Disease				
Cirrhosis of Liver				
Hepatitis C				

Have you ever had any of the following gastrointestinal diseases: (circle all that apply)

Gallbladder Disease Colon Polyps Acid Reflux Disease Irritable Bowel Syndrome

Peptic Ulcer Disease Colon Cancer Crohns Disease Hiatal Hernia

Ulcerative Colitis Hemorrhoids Diverticular Disease Hepatitis C

Have you ever had any of the following procedures?

Procedure:	Date:	Result (if known):
Colonoscopy		
EGD (scope of stomach)		
Barium Enema		
Upper GI X-ray		
Abdominal Ultrasound		
CT Scan of Abdomen		
MRI of Abdomen		

Have you recently had pain in your stomach Y N (Check all that apply)

___Occurs 1-2 hrs after meals ___Brought on by eating greasy fried foods

___Awakens you at night ___Relieved temporarily by antacid medications

___Relieved with milk or eating ___Occurs while eating or immediately after

___Relieved by a bowel movement or passage of gas ___ Burning or gnawing type discomfort

___It travels to your right shoulder or between your shoulder blades

Patient Name ______________________________ D/O/B ________________

Have you recently had a change in bowel habits Y N (Check any that relate to your symptoms)

___Crampy pain in abdomen ___Alternating diarrhea and constipation

___Diarrhea ___Constipation

___Pain during or after bowel movement ___Bright red rectal bleeding with every bowel movement

___Bright red rectal bleeding infrequently ___Blood streaked on outside of stool

___Blood mixed in stool ___Blood dripping into toilet bowl

___Mucous in stools ___Pencil thin stools ___Ribbon like stools ___Black stools, tarry, liquid-like

___Require use of strong laxatives or enemas frequently

___Sense of incomplete evacuation after a normal bowel movement

___Symptoms associated with your menstrual cycle (if applicable)

Patient Name ____ D/O/B ____________________