



PATIENT HISTORY

Today's date _____



PATIENT: _____ REFERRING PHYSICIAN: _____ AGE: _____ DATE OF BIRTH: _____

PATIENT PROFILE (CHECK ONE)

Married Divorced Single Separated Widowed

OCCUPATION: _____

HABITS: Tobacco Use: Y/N

Alcohol Use: Y/N Amount per day: _____

Caffeine Use: Y/N Amount per day: _____

Last Completed Medical Examination: _____

Last Colonoscopy: _____

SYMPTOMS AND OTHER CONDITIONS PAST AND PRESENT (Circle all that apply)

General

Fever Anorexia
Chills Malaise
Sweats Fatigue
Weight loss

Eyes

Blurring Double Vision
Discharge Irritation
Vision loss

Ear/Nose/throat

Difficulty swallowing Nosebleeds
Loss of hearing Sore throat
Nasal obstruction Hoarseness

Cardiovascular

Chest pain High Blood Pressure
Short of air Syncope
Stents Edema (swelling in
Heart Murmur extremities)

Respiratory

Short of Breath Wheezing
Asthma Night Sweats
Tuberculosis Excessive Sputum
Cough

Gastrointestinal

Nausea Vomiting
Diarrhea Blood in stool
Constipation Jaundice
Change in Bowel Habits Abdominal Pain

Genitourinary

Nipple Discharge Incontinence
Kidney infections Kidney Stones
Urination Urgency or Venereal Disease
Retention Libido-changes in
Impotence

Muculoskeletal

Back Pain Muscle weakness
Joint pain Stiffness
Joint Swelling Arthritis
Muscle Cramps

SYMPTOMS AND OTHER CONDITIONS cont.

Skin

Rash Itching
Discharge Dryness
Suspicious lesions

Neurologic

Paralysis Fainting Spells
Seizures Tremors
Vertigo/dizziness Hoarseness
Difficulty with memory Lack of Coordination

Psychiatric

Depression Emotional Problems
Anxiety Suicidal Ideation
Memory loss Hallucinations
Paranoia

Endocrine

Cold intolerance Weight Changes
Heat intolerance Excessive thirst
Thyroid Problems Excessive cravings
Lymph Node Swelling

Hematologic/Lymphatic

Bruising
Bleeding
Enlarged lymph nodes

Allergic Immunologic

Rash Persistent infections
HIV exposure

FAMILY HISTORY CANCER

Relative _____ Cancer _____

GI Cancers: Colon Esophagus Liver Pancreas

GI Illnesses: Ulcers Colitis Crohn's Celiac Sprue

SURGERIES: List previous surgeries _____

REASON FOR TODAY'S VISIT (SYMPTOMS)

Do you currently have any of these symptoms or conditions?
(Mark all that apply – if no symptoms, please mark "none")

- | | |
|---|---|
| <input type="checkbox"/> heartburn/indigestion/reflux | <input type="checkbox"/> belching |
| <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> irregular bowel habits |
| <input type="checkbox"/> painful swallowing | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> constipation |
| <input type="checkbox"/> nausea | <input type="checkbox"/> incontinence of stool |
| <input type="checkbox"/> vomiting | <input type="checkbox"/> black stools |
| <input type="checkbox"/> get full quickly at meals | <input type="checkbox"/> blood in stool |
| <input type="checkbox"/> abdominal distention | <input type="checkbox"/> jaundice/yellow skin color |
| <input type="checkbox"/> gas/flatulence | <input type="checkbox"/> vomiting blood |
| <input type="checkbox"/> bloating | <input type="checkbox"/> hernia |
| <input type="checkbox"/> laxative use | <input type="checkbox"/> food/milk intolerance |
| <input type="checkbox"/> pain with bowel movement | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> none |