



PATIENT HISTORY

Today's date _____

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

Preferred Lanaguage: English, French, German, Italian, Mandarin, Vietnamese, or Spanish: _____

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: _____

- Smoking Status:** never smoker former smoker
 current some day smoker current every day smoker
 unknown if ever smoked smoker, current status unknown

Last Completed Medical Examination: _____

Last Colonoscopy: _____

Ethnicity options:

- Hispanic or Latino
- Non-Hispanic or Non-Latino
- Other or Undetermined

SYMPTOMS AND OTHER CONDITIONS RECENT (Circle all that apply)

General			
Fever	Chills	Anorexia	Malaise
Sweats	Weight loss	Fatigue	
Eyes			
Blurring	Discharge	Double Vision	
Vision loss		Irritation	
Ear/Nose/throat			
Difficulty swallowing		Nosebleeds	
Loss of hearing		Sore throat	
Nasal obstruction		Hoarseness	
Cardiovascular			
Chest pain	Stents	High Blood Pressure	
Short of air		Syncope	
Heart Murmur		Edema (swelling in extremities)	
Respiratory			
Short of Breath	Asthma	Wheezing	Night Sweats
Tuberculosis	Cough	Excessive Sputum	
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 Retention		Venereal Disease	
Impotence		Libido-changes in	
Muculoskeletal			
Back Pain	Joint pain	Muscle weakness	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