Constitutional

❑ None ❑ Weight Gain ❑ Chills
❑ Weight Loss ❑ Fatigue ❑ Fever
❑ Night Sweats ❑ Loss Of Appetite
❑ Other (Specify): _____

Psychiatric

❑ None ❑ Inability To Concentrate
❑ Anxiety/Panic ❑ Suicidal Thoughts
❑ Depression ❑ Difficulty Sleeping
❑ Other (Specify) _____

Eyes

❑ None ❑ Wear Glasses/Contacts
❑ Blurred Vision ❑ Pain
❑ Light Sensitivity ❑ Visual Decline
❑ Other (Specify) _____

Hematologic

❑ None ❑ Prolonged Bleeding
❑ Abnormal Blood Clotting ❑ Swollen Glands
❑ Other (Specify):

Ear, Nose And Throat

❑ None ❑ Nose Bleeds ❑ Hearing Loss
❑ Sore Throat ❑ Hoarseness
❑ Other (Specify) _____

Musculoskeletal

❑ None ❑ Muscle Pain ❑ Back Pain
❑ Stiffness ❑ Joint Pain
❑ History Of Joint Replacement
Or Any Other (Specify) _____

Respiratory

❑ None ❑ Wheezing ❑ Coughing
❑ Coughing Blood
❑ Other (Specify): _____

Immunologic

❑ Allergies ❑ HIV Exposure
❑ Persistent Infections ❑ Immune Deficency
❑ Recurrent Hives ❑ Strong Allergic Reactions
❑ Other (Specify): _____

Family History

	Father	Mother	Child(ren)	Brother(s)	Sister(s)	Grandparents
Bleeding	❑	❑	❑	❑	❑	❑
Breast Cancer	❑	❑	❑	❑	❑	❑
Celiac Disease	❑	❑	❑	❑	❑	❑
Colitis	❑	❑	❑	❑	❑	❑
Colon Cancer	❑	❑	❑	❑	❑	❑
Colon Polyps	❑	❑	❑	❑	❑	❑
Crohn's Disease	❑	❑	❑	❑	❑	❑
Deceased	❑	❑	❑	❑	❑	❑
Esophageal Cancer	❑	❑	❑	❑	❑	❑
Healthy	❑	❑	❑	❑	❑	❑
Liver Disease	❑	❑	❑	❑	❑	❑
Ovarian Cancer	❑	❑	❑	❑	❑	❑
Pancreatic Cancer	❑	❑	❑	❑	❑	❑
Stomach Cancer	❑	❑	❑	❑	❑	❑
Uterine Cancer	❑	❑	❑	❑	❑	❑
Other (Specify) list below	❑	❑	❑	❑	❑	❑

Medications History

Current Daily Medications: Include Prescriptions, Over-The-Counter, Vitamins And Herbal Medications

Medication	Dosage/ Frequency

MEDICAL HISTORY FORM

Please bring this in with you on the day of your procedure

Allergies

- ❑ None
- ❑ Latex
- ❑ Aspirin
- ❑ Morphine
- ❑ Codeine
- ❑ Penicillin
- ❑ Demerol
- ❑ Sulfa
- ❑ Eggs
- ❑ Versed
- ❑ Iodine
- ❑ Other

Past Illnesses

- ❑ None
- ❑ Heart Attack
- ❑ Osteoporosis
- ❑ Depression
- ❑ Lactose Intolerance
- ❑ Atrial. Fib
- ❑ Hepatitis A
- ❑ Rheumatic Fever
- ❑ Diverticulitis
- ❑ Migraines
- ❑ Back Pain
- ❑ Hepatitis C
- ❑ STD
- ❑ Duodenal Ulcer
- ❑ Osteoarthritis
- ❑ Cancer
- ❑ High Blood Pressure
- ❑ Sleep Apnea
- ❑ Endocarditis
- ❑ Pancreatitis
- ❑ Cirrhosis
- ❑ High Triglycerides
- ❑ Stroke/Paralysis
- ❑ Urinary Infections
- ❑ Parkinson's Disease
- ❑ Colon Cancer
- ❑ Irregular Heartbeat
- ❑ Thyroid Disease
- ❑ Glaucoma
- ❑ Pneumonia
- ❑ Congestive Heart Failure
- ❑ Kidney Disease/Failure
- ❑ Uterine Cancer
- ❑ Crohn's Disease
- ❑ Kidney Stones
- ❑ Anemia
- ❑ Heart Murmur
- ❑ Reflux
- ❑ Diabetes
- ❑ Lupus
- ❑ Asthma
- ❑ Hepatitis B
- ❑ Seizures
- ❑ Diverticulosis
- ❑ MRSA
- ❑ Breast Cancer
- ❑ Hiatal Hernia
- ❑ Skin Cancer
- ❑ Emphysema/COPD
- ❑ Osteoporosis
- ❑ Chronic Lung Disease
- ❑ High Cholesterol
- ❑ Stomach/Duodenal Ulcers
- ❑ Fatty Liver
- ❑ Paralysis
- ❑ Colitis
- ❑ HIV/AIDS
- ❑ TB Or Positive TB Test
- ❑ Gallstones
- ❑ Phlebitis
- ❑ Colon Polyps
- ❑ Irritable Bowel
- ❑ Ulcerative Colitis
- ❑ Gout
- ❑ Osteoarthritis

Previous Operations Or Treatments

- ❑ None
- ❑ Hemorrhoid
- ❑ Tonsils
- ❑ Colonoscopy
- ❑ Obesity Surgery
- ❑ Breast
- ❑ Hiatal Hernia
- ❑ C-Section
- ❑ Hysterectomy
- ❑ Groin Hernia Surgery
- ❑ Groin Hernia
- ❑ Thyroid
- ❑ Colon Resection
- ❑ Liver Biopsy
- ❑ Appendix
- ❑ Hernia
- ❑ Upper Endoscopy/EGD
- ❑ ERCP
- ❑ Prostate Surgery
- ❑ Gallbladder
- ❑ Stomach Surgery
- ❑ Cardiac Surgery
- ❑ Kidney
- ❑ Heart Valve Replacement
- ❑ Other (Specify): _____

_____

_____

_____

_____

Social History Marital Status

- ❑ Single
- ❑ Separated
- ❑ Married
- ❑ Divorced
- ❑ Widowed
- ❑ Domestic Partnership

Social History Exercise

- ❑ I Do Not Exercise
- ❑ Jog
- ❑ Swim
- ❑ Aerobics
- ❑ Walk
- ❑ Bike
- ❑ Golf
- ❑ Lift Weights

Social History Alcohol

- ❑ Never
- ❑ > 2 A Week
- ❑ Rarely
- ❑ < 2 A Week
- ❑ Daily
- ❑ Stopped Using

Social History Tobacco

- ❑ I Use Tobacco Products
- ❑ I Have Never Used Tobacco
- ❑ I Quit Using Tobacco

Do You Currently Have Any Of The Following Symptoms?

Gastrointestinal

- ❑ None
- ❑ Bloating
- ❑ Difficulty Swallowing
- ❑ Rectal Bleeding
- ❑ Blood In Stool
- ❑ Mucous In Stool
- ❑ Anal/Rectal Pain
- ❑ Heartburn
- ❑ Soiling/Incontinence
- ❑ Constipation
- ❑ Pain w/Bowel Movement
- ❑ Black Stools
- ❑ Lactose Intolerance
- ❑ Abdominal Pain
- ❑ Gas
- ❑ Rectal Urgency
- ❑ Change In Bowel Habits
- ❑ Nausea
- ❑ Belching
- ❑ Hemorrhoids
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Other (Specify): _____

Genitourinary

- ❑ None
- ❑ Change In Urinary Frequency
- ❑ Urinary Incontinence
- ❑ Other (Specify) _____
- ❑ Std
- ❑ Testicle Problem
- ❑ Kidney Stones
- ❑ Pain With Urination

Skin

- ❑ None
- ❑ Jaundice
- ❑ Lesions
- ❑ Other (Specify): _____
- ❑ Itching
- ❑ Rash

Cardiovascular

- ❑ None
- ❑ Heart Murmur
- ❑ Palpitations
- ❑ Shortness Of Breath When Lying Flat
- ❑ Shortness Of Breath With Exertion
- ❑ Other (Specify) _____
- ❑ Chest Pain
- ❑ Ankle Swelling
- ❑ Valve Replacement

Neurological

- ❑ None
- ❑ Dizziness
- ❑ Fainting
- ❑ Other (Specify) _____
- ❑ Memory Loss
- ❑ Numbness In Extremities
- ❑ Headaches

Endocrine

- ❑ None
- ❑ Cold Intolerance
- ❑ Other (Specify) _____
- ❑ Hair Change
- ❑ Excessive Thirst