

Patient Name: \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_  
 Reason for this visit: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Please list any past medical problems or injuries you have had: \_\_\_\_\_

Please list any past surgical problems and describe any operations you have had: \_\_\_\_\_

Operations:	Year	Hospital
1. _____		
2. _____		
3. _____		

Please list any drugs you are allergic to:  
 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

Have you had an anesthesia reaction? Yes No If so, when and please describe: \_\_\_\_\_  
 Have you had previous gastroscopy? Yes No Colonoscopy? Yes No CT Scan? Yes No  
 UGI series? Yes No Barium Enema? Yes No Sonogram? Yes No

If so, when, and where? \_\_\_\_\_  
 What were the results? \_\_\_\_\_

Please list all current medications. Drugs (include aspirin) and Herbal Medicines.


Do you have any cardiac condition, such as mitral valve prolapse, requiring antibiotics for dental work? Yes No

Do you have any bleeding tendencies? Yes No

Do you smoke? Yes No If yes, how many? \_\_\_\_\_

Have you had any of the following? Please mark the appropriate box with an "X":

	Yes	No		Yes	No
High blood pressure			Stomach ulcer		
Low blood pressure			Loss of weight		
Blood transfusion			Loss of appetite		
Heart trouble			Belching, heartburn		
Chest pain			Black, tarry stools		
Shortness of breath			Urinary difficulty		
Palpitations			Kidney stone		
Recent cardiac problems			Urine infection		
Please explain:			Frequent urination		
Jaundice			Date of last gynecological exam		
Abdominal pain			Abnormal vaginal bleeding		
Chronic cough			Phlebitis		
Nausea			Arthritis		
Vomiting			Pain in extremities		
Diarrhea			Family history of colon polyps or colon cancer		
Constipation			Family history of peptic ulcer		
Rectal pain or bleeding			Hemorrhoid trouble		
Recent change in bowel habits			Number of bowel movements per day		
Alcohol abuse			Pancreatitis		
IV drug use			Other family history of cancer		

**PLEASE USE THE BACK OF THIS SHEET FOR ANY ADDITIONAL INFORMATION OR COMMENTS WHICH YOU FEEL MIGHT BE OF INTEREST.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

MD Signature: \_\_\_\_\_ Date: \_\_\_\_\_

MD Comments: \_\_\_\_\_

