

AFFILIATES IN GASTROENTEROLOGY, P. A.
Medical History for Colonoscopy

Name _____ Today's Date _____

Birthdate _____ Referring Doctor _____

Reason for Colonoscopy: _____ Screening _____ Problem. If problem, what is it and the duration of time _____

Medical Problems/Past Medical History (i.e. high blood pressure, diabetes, ulcers, cancer, hepatitis, colitis, etc)

Previous Surgeries (with dates):

Medications, Vitamins, Supplements (with strength and dosage): (use additional sheet if necessary)

Do you take a blood thinner? If yes, which one? _____

Do you have a pacemaker? _____ Defibrillator? _____

Have you ever had a colonoscopy? Yes No When? _____

Have you ever had an upper endoscopy? Yes No When? _____

Do you have any allergies to medications? Yes No What Medicine? _____

If yes, describe reaction: _____

Do you use aspirin, Advil, Motrin, etc? _____ How often? _____

Do you smoke? Yes No If yes, How many cigarettes per day? _____

Do you drink alcohol? Yes No If yes, how much per week? _____

Have you had a blood transfusion? Yes No If yes, when? _____

Any family diseases? (i.e., cancer, heart, diabetes, colitis, liver) If so, whom? _____

Women only: When was your last menstrual period? _____

PLEASE COMPLETE PAGE 2, RETURN ALL FORMS TO THE OFFICE

medical history form cln aug 2011.doc

Do you now have or have you ever had:

When, Frequency, Duration, etc.

Problems Swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Painful Swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gas Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abdominal Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemorrhoids	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rectal Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vertigo (room spinning)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visual Disturbances	<input type="checkbox"/> Yes <input type="checkbox"/> No
Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Difficulty	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rash or Hives	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swollen Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recurrent Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Post Nasal Drip	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough (chronic)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma/Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty or Pain Urinating	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive Urination	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight Loss (recent)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight Gain (recent)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal Menses (women)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling of hands, fee	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Easy Bruising/Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seasonal Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No

Print Patient's Name _____ Signature _____