

PATIENT HISTORY FORM REVIEW OF SYSTEMS

Name: _____

Date of Birth: _____

Constitutional

Recent Weight Change ___ YES ___ NO
Fever ___ YES ___ NO
Fatigue ___ YES ___ NO

Eyes

Blurred Vision ___ YES ___ NO
Glaucoma ___ YES ___ NO

Ears/Nose/Mouth/Throat

Hearing Loss ___ YES ___ NO
Ringing in Ears ___ YES ___ NO
Mouth Sores ___ YES ___ NO

Cardiovascular

Chest Pain ___ YES ___ NO
Shortness of Breath ___ YES ___ NO
Swelling of Ankles ___ YES ___ NO

Respiratory

Chronic Cough ___ YES ___ NO
Spitting up Blood ___ YES ___ NO
Wheezing ___ YES ___ NO

Genitourinary

Burning with Urination ___ YES ___ NO
Blood in Urine ___ YES ___ NO

Musculoskeletal

Joint Pain ___ YES ___ NO
Swelling ___ YES ___ NO
Back Pain ___ YES ___ NO
Muscle Pain ___ YES ___ NO

Skin

Rash ___ YES ___ NO
Itching ___ YES ___ NO

Gastrointestinal

Poor Appetite ___ YES ___ NO
Difficulty in Swallowing ___ YES ___ NO
Heartburn ___ YES ___ NO
Nausea ___ YES ___ NO
Vomiting ___ YES ___ NO
Bloating ___ YES ___ NO
Belching ___ YES ___ NO
Regurgitation ___ YES ___ NO
Constipation ___ YES ___ NO
Diarrhea ___ YES ___ NO
Abdominal Pain ___ YES ___ NO
Recent Change in Bowel Habits ___ YES ___ NO
Rectal Bleeding ___ YES ___ NO
Black, Tarry Stools ___ YES ___ NO

Neurological

Headaches ___ YES ___ NO
Seizures ___ YES ___ NO
Numbness ___ YES ___ NO
Strokes ___ YES ___ NO

Psychiatric

Memory Loss or Confusion ___ YES ___ NO
Depression ___ YES ___ NO

Endocrine

Heat Intolerance ___ YES ___ NO
Cold Intolerance ___ YES ___ NO
Excessive Thirst ___ YES ___ NO
Excessive Urination ___ YES ___ NO

Hematological

Bleeding Tendency ___ YES ___ NO
Bruising Tendency ___ YES ___ NO
Past transfusion ___ YES ___ NO
Anemia ___ YES ___ NO
Are you Pregnant? ___ YES ___ NO

Do you take any blood thinners? No Yes **What Medication** _____

Medication Allergies: _____

List of Medications and Doses: _____

Comments/Concerns: _____

PATIENT HISTORY FORM

Name _____ Date of Birth _____
 Race: White Asian African American Native Hawaiian/Other Pacific Islander American Indian/Alaskan Native
 Ethnicity: Hispanic/Latino Non Hispanic/Latino Language: _____ Height: _____ Weight: _____
 Primary Care Physician: _____ Pharmacy: _____ Location: _____
 Reason for today's visit: _____

List all prior surgeries and date: _____

Circle Present and Past Medical History:

Anemia Angina Anxiety Arrhythmia Arthritis Asthma Blood Clot in Leg or Lung Bronchitis Cancer Congestive Heart Failure Constipation Crohn's Disease Depression Diabetes Elevated Cholesterol Emphysema Heart Attack Heart Murmur Hepatitis Hiatal Hernia Hypertension Irritable Bowel Syndrome Peptic Ulcer Reflux Rheumatic Fever Seizure Sleep Apnea Stroke Thyroid Disease Tuberculosis Ulcerative Colitis
 Other: _____

Have you ever had a colonoscopy before?
 No Yes
 If so, when and where? _____

Have you ever smoked? No Yes
 If currently smoking, how many packs per day? _____
 If not currently smoking, quit date: _____

Have you ever had any problems with anesthesia or sedation? No Yes
 If yes, what happened? _____

Do you drink alcohol? None Occasional Daily
 Recreational drug use? No Yes
 Marital Status: Single Married Divorced Widowed
 Do you work? No Yes Type of Work: _____

Any family history of liver disease, celiac disease, Crohn's, ulcerative colitis, other cancer? _____
 Family History Colon Polyps: No Yes Whom: _____
 Family History Colon Cancer: No Yes Whom: _____
 Family History of Other Significant Disease(s): _____

To Be Completed by Gastroenterologist on day of exam:

HPI: _____

Physical Examination:	BP _____	Hgt _____	Wgt _____	Yes	No	Comments
1. Constitutional: Well-nourished/well developed:				<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Skin: Skin free of rashes, purpura, petechiae, stigmata:				<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Eyes: Lids and Conjunctivae normal:				<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Ears/Nose/Mouth/Throat: Is the oral mucosa pink/moist				<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Hematologic/Lymphatic/Immunologic: Nodes in neck nl:				<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Respiratory: Lungs clear to auscultation:				<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Cardiovascular: Heart rate regular & no murmur:				<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Gastrointestinal: Soft, nl tympany, active bs, no hsm no masses, no tenderness				<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Musculoskeletal: No clubbing, deformities, edema of extremities				<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Rectal: Hem occult negative:				<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Neurologic: Intact				<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Psychiatric: Alert, oriented to time/person/place				<input type="checkbox"/>	<input type="checkbox"/>	_____

Reviewed By _____ Date: _____

ASA: _____

I have reassessed the patient and find no changes to the above
 Reviewed By _____ Date: _____