

**Providing Information About Your Health
Is Very Important. Please Take the Time
To Fully Complete This Form.**



MEDICAL & FAMILY HISTORY FORM

NAME: _____ **DATE OF BIRTH:** _____ **TODAY'S DATE:** _____

Reason for Visit: _____

Medications — Please list all of your current prescription and non-prescription medications, vitamins and supplements OR let us copy a pre-existing list)

NONE <input type="checkbox"/>		

Past Medical History

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Cirrhosis of liver | <input type="checkbox"/> Groin hernia | <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Colon cancer | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Colon polyps | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Lupus | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Migraines | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Milk intolerance | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Chest pain/angina | <input type="checkbox"/> Duodenal ulcer | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Ovarian cyst | <input type="checkbox"/> Stomach ulcer |
| <input type="checkbox"/> Chronic anxiety | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High triglycerides | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Stroke or paralysis |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Fatty liver | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> TB (Tuberculosis) |
| <input type="checkbox"/> Chronic lung disease | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Peptic ulcer | <input type="checkbox"/> TB skin test positive |
| <input type="checkbox"/> Chronic sinusitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Cancer type: _____ | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney disease/failure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcerative colitis |

Allergies (Please indicate Reaction to each Allergy)

- None
 Penicillin
 Sulfa
 Aspirin
 Iodine
 Latex
 Codeine
- Others: _____

Surgeries/Procedures

- | | | | | | |
|--|--------------------------------------|---------------------------------------|---|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Colostomy | <input type="checkbox"/> Groin hernia | <input type="checkbox"/> Hemorrhoid surgery | <input type="checkbox"/> Liver biopsy | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> C-section | <input type="checkbox"/> Heart bypass | <input type="checkbox"/> Hiatal hernia repair | <input type="checkbox"/> Obesity surgery | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Breast | <input type="checkbox"/> EGD | <input type="checkbox"/> Heart stent | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Ovary | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Colon surgery | <input type="checkbox"/> ERCP | <input type="checkbox"/> Heart valve | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Prostate | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Kidney | <input type="checkbox"/> Sigmoidoscopy | <input type="checkbox"/> Uterus | |

Date of last Colonoscopy: _____ **Other:** _____

PLEASE TURN OVER



Name: _____ DOB: _____

Family History	Father	Mother	Grandparents	Siblings	Children
Healthy	<input type="checkbox"/>				
Deceased	<input type="checkbox"/>				
Colon polyps	<input type="checkbox"/>				
Colon cancer	<input type="checkbox"/>				

Social History

Marital status married sin separated divorced widowed partnered

Occupation: _____ unemployed retired

Smoking history: never yes; _____ packs per day for _____ years **Age started** ____ **stopped** ____
Currently smoking? no yes
Other tobacco use no yes; details: _____
Alcohol use no yes; amount per day: _____ for _____ years
Drug use no yes; specify drugs and amounts: _____

Exercise no yes; how much and how often: _____

Hobbies none yes; specify: _____

Recent travel outside US? no yes; where: _____

Review of Systems – check all that apply at the present time

General

- fever or chills
- loss of appetite
- weight gain
- weight loss
- weakness, fatigue

Gastrointestinal

- abdominal distention
- abdominal pain/cramping
- belching
- black stools
- blood in stool
- change in bowel habits
- constipation
- diarrhea
- difficulty swallowing
- fat intolerance
- full after eating small amounts
- gas/bloating
- heartburn
- indigestion
- hemorrhoids
- jaundice
- nausea or vomiting
- pain with swallowing
- poor appetite
- rectal bleeding
- rectal pain
- regurgitation of food
- soiling/incontinence
- vomiting blood

Cardiovascular

- chest pain or tightness
- rapid or irregular heart beat
- shortness of breath
- swelling of legs
- varicose veins

Respiratory

- chronic cough
- wheezing
- shortness of breath
- need for oxygen therapy

Urinary

- pain or difficulty with urination
- frequent urination
- blood in urine
- incontinence of urine

Musculoskeletal

- stiff or painful joints
- swollen joints
- back pain
- muscle pain

Hematologic

- frequent bruising
- bleeding doesn't stop easily

Endocrine

- heat or cold intolerance
- excessive thirst or urination
- steroid therapy (prednisone)

Genitoreproductive - Male

- discharge from penis
- testicular pain or lump

Genitoreproductive - Female

- heavy periods
- date of last period: _____

Dermatologic

- rash or hives
- itching
- tattoos

Neurologic

- numbness or tingling
- dizziness or lightheadedness
- vertigo
- headaches
- weakness in arms or legs
- blurred vision
- difficulty with memory

Psychiatric

- anxiety
- depression
- panic attacks
- tired on waking up in morning

Immunizations

- Hepatitis A
- Hepatitis B

