PATIENT HISTORY

Name _____

Gender M ☐ F ☐ Age ____ Exam/Proc Date _____ Birth Date _____

Prescription Medications

☐ None	Dose	Frequency
Coumadin Yes No Why?		
MAO Inhibitors Yes No		
(Nardil Parnate Marplan Selegiline)		

Over the Counter Medications

☐ None	Dose	Frequency
Aspirin Yes No Why?		
NSAIDS Yes No		

Vitamins (including herbals, home remedies)

☐ None	Dose	Frequency
Iron Yes No		

Medication Allergies

☐ None	Circle Reaction
	Shortness of breath, hives, rash, itching, other
	Shortness of breath, hives, rash, itching, other
	Shortness of breath, hives, rash, itching, other
	Shortness of breath, hives, rash, itching, other
	Shortness of breath, hives, rash, itching, other

Latex Allergy YES NO

	Shortness of breath, hives, rash, itching, other

Chief Complaint (Describe symptoms and problems)

Medications used for this complaint:
(include previous meds not currently prescribed)

Testing Performed
(including previous Endoscopy)

☐ None *X-rays, Lab, Procedures*

Other Physicians Treating Conditions

☐ None Relating to Chief Complaint

Immediate Family History of Disease

History of:	Relationship (Father, sister, etc.)
Yes No Colon Cancer	
Yes No Crohn's Disease	
Yes No Liver Disease	
Yes No Pancreatitis	
Yes No Sprue	
Yes No Ulcers	
Yes No Ulcerative Colitis	

Patient's Height and Weight

Height ft. in.	Weight lbs.

Review of Systems — Circle problems in past year.

Gastrointestinal
☐ No symptoms
Abdominal Pain
Change in bowel habits
Constipation
Decreased appetite
Diarrhea
Diverticulosis/Diverticulitis
Heartburn
Hemorrhoids
Indigestion
Inflammatory bowel disease
Jaundice/hepatitis
Nausea/vomiting
Pancreatitis
Previous colon polyp/tumor
Rectal bleeding
Trouble swallowing
Ulcer
_____

Respiratory
☐ *No symptoms*
Asthma or emphysema
Chronic cough
Coughing up blood
Hx-pulmonary embolism
Oxygen Therapy
Pneumonia
Shortness of breath
_____

Cardiovascular
☐ *No symptoms*
Chest pain
Heart attack
Heart murmur
High blood pressure
Irregular/rapid heart beat
Low blood pressure
Pacemaker/Defibrillator
Swelling of ankles/feet
Valve replacement
PTCA or Stent (last 30 dys)
_____
_____

Genitourinary
☐ *No symptoms*
Blood in urine
Kidney stones
Kidney disease
Renal Failure/**Dialysis**

Infectious Disease
☐ *No symptoms*
Hepatitis (A,B,C)
Tuberculosis

Muscles-Joints-Bones
☐ *No symptoms*
Artificial joints
Arthritis
Back or neck injury
_____

Endocrine
☐ *No symptoms*
Cortisone therapy
Diabetes
Thyroid problem/goiter
_____

Ear-Nose-Throat
☐ *No symptoms*
Bleeding gums
Dentures
Hearing loss
Hoarseness
Nosebleeds
Sinus problems
Sores in mouth
_____
_____

Skin
☐ *No symptoms*
Rash
Itching
Sores that won't heal
_____
_____

Eyes
☐ *No symptoms*
Glaucoma
_____
_____

Lymphatic
☐ *No symptoms*
Anticoagulation therapy
Blood disorder/anemia
Phlebitis/Blood Clots
_____

Neurologic
☐ *No symptoms*
Paralysis
Recurrent headache
Seizures/Epilepsy
Stroke
_____
_____
_____

Mental Health
☐ *No symptoms*
Depression
Panic attacks/Anxiety
Phobias
_____
_____
_____

Constitutional
☐ *No symptoms*
Recent weight loss
Recent weight gain
_____
_____
_____

Past Medical History

yes no **Past Blood Transfusions**

yes no **Complications with IV Sedation**

Explain

Surgeries & Major Hospitalizations

Yr	

Social History — X Mark Answers

Caffeine Intake
___ None
Coffee ____ cups/day
Decaf ____ cups/day
Tea ____ cups/day
Cola ____ 8 oz glasses/day
Other_____

Tobacco
___ Does not smoke
___ Never smoked
___ Smokes:
___ Cigarettes
___ Packs____per day
___ Quit smoking_____years ago

Alcohol None ___
___ Social use
___ Binge drinker
___ Reformed alcoholic
___ Beers per day
___ Shots per day
___ Ounces per day
___ Glasses of wine/day
___ Bottles of wine/day
___ Fifths per day

Drugs
Does NOT use drugs ____
IV drug user (include previous) ____
Recreational ____

Marital Status (circle one)
Married Single
Separated Divorced
Widowed

Children yes no # _____

Occupation
_____

Living Arrangements
lives with:
spouse____ family____
*alone*____ *friends*____
significant other____
shelter:
home____ homeless____
nursing home_____
assisted living ____

Comments of underlying condition(s): _____

Signature _____ ***Date*** _____

Updated Hx Changes ***Date changes noted*** _____

Patient initials _____ ***Nurses Signature*** _____

I certify that the above information is correct to the best of my knowledge. I will not hold my physician or any member of their staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ ***Date*** _____ ***Physician Signature*** _____ ***Date*** _____