

Today's Date: \_\_\_\_\_

Referred by: \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_  
Birthdate \_\_\_\_\_ Home Tel: ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_ Work Tel:( ) \_\_\_\_\_

**SOCIAL HISTORY**

Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_ # of children \_\_\_\_\_ Sons \_\_\_\_\_ Daughters \_\_\_\_\_

**HABITS**

Smoke \_\_\_\_\_ Packs Daily \_\_\_\_\_ How Long \_\_\_\_\_ When Stopped \_\_\_\_\_  
Exercise Routine \_\_\_\_\_  
Coffee \_\_\_\_\_ Cups Daily \_\_\_\_\_ Other Caffeines \_\_\_\_\_  
Alcohol \_\_\_\_\_

**DRUG ALLERGIES** (List all)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please list all CURRENT MEDICATIONS**

Include vitamins, herbs, diet medications etc.

Name \_\_\_\_\_ Dosage / # times daily \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous Gerd/heartburn medications used: \_\_\_\_\_

**FAMILY HISTORY** (including parents, grandparents, siblings, etc.)

Mother : Alive / Deceased \_\_\_\_\_ Father: Alive / Deceased \_\_\_\_\_ Adopted: Yes / No \_\_\_\_\_  
Asthma \_\_\_\_\_ Diabetes \_\_\_\_\_  
Heart Disease \_\_\_\_\_ Epilepsy \_\_\_\_\_  
Hypertension \_\_\_\_\_ Ulcer Disease \_\_\_\_\_  
Stroke \_\_\_\_\_ Kidney Disease \_\_\_\_\_  
Cancer \_\_\_\_\_ Arthritis \_\_\_\_\_  
Colon Cancer/Polyps \_\_\_\_\_ Anemia \_\_\_\_\_

**SURGERY**

Reason \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OTHER HOSPITALIZATIONS**

Reason \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL HISTORY**

**Previous Colonoscopy Y/N when: \_\_\_\_\_ polyps Y/N**

**Previous EGD Y/N when: \_\_\_\_\_ findings:**

Do you have or have you had any of the following? (Please check all that apply)

<input type="checkbox"/> Alcoholism _____	<input type="checkbox"/> Dizziness/Fainting _____	<input type="checkbox"/> Liver Disease _____
<input type="checkbox"/> Allergies/Hay Fever _____	<input type="checkbox"/> Emphysema _____	<input type="checkbox"/> Menstruation Dysfunction _____
<input type="checkbox"/> Anemia _____	<input type="checkbox"/> Endocrine Disease _____	<input type="checkbox"/> Other Gynecological Disorder _____
<input type="checkbox"/> Anxiety _____	<input type="checkbox"/> Epilepsy _____	<input type="checkbox"/> Renal Disease _____
<input type="checkbox"/> Arrhythmia _____	<input type="checkbox"/> Gallbladder _____	<input type="checkbox"/> Rheumatic Fever _____
<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> GI Disorder _____	<input type="checkbox"/> Scarlet Fever _____
<input type="checkbox"/> Artificial Heart Valve _____	<input type="checkbox"/> Glaucoma _____	<input type="checkbox"/> Sexual Dysfunction _____
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Gout _____	<input type="checkbox"/> Shortness of Breath _____
<input type="checkbox"/> Blood Transfusions _____	<input type="checkbox"/> Heart Attack _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Chest Pain/Angina _____	<input type="checkbox"/> Heart Murmur _____	<input type="checkbox"/> Ulcer _____
<input type="checkbox"/> Colon Polyps _____	<input type="checkbox"/> Heart Palpitations _____	<input type="checkbox"/> Urological Disorder _____
<input type="checkbox"/> Congenital Heart Disease _____	<input type="checkbox"/> Hepatitis: A _____ B _____ C _____	<input type="checkbox"/> Vascular Heart Disease _____
<input type="checkbox"/> Congestive Heart Failure _____	<input type="checkbox"/> Hyperlipidemia _____	<input type="checkbox"/> Venereal Disease _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Hypertension _____	<input type="checkbox"/> Cancer type: _____