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PATIENT HISTORY FORM

Last name:	**First name:**	**MI**	**Date of Birth:**	**Age:**
Marital Status: Single. Divorced. Married. Widow/er		Who lives with you?		
Employer:	Occupation	What kind of work?		
Primary care physician		Other doctors involved with your case:		

REVIEW OF SYSTEMS

Have you or the patient ever been diagnosed with any of the following? If yes, please check any that apply and explain in the space provided. Is your family physician aware of any symptoms/illness that you have checked below? ☐Yes ☐No

SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES	Medical History	NO	YES
Gastrointestinal			**Cardiac**			**Neurology**			**Hypertension**		
Abdominal pain			High blood pressure			Dizziness			**Diabetes Mellitus**		
Nausea/vomiting			Low blood pressure			Headache			**Heart Disease/CAD**		
Heartburn			Irregular heartbeat			**Musculoskeletal**			**COPD/Emphysema**		
Diarrhea			Chest pain			Muscle pain			**Renal Disease**		
Constipation			**Respiratory**			Arthritic pain			**High Cholesterol**		
Change in BMs			Asthma			Neck/ Back pain			**Hypothyroidism**		
Rectal bleeding/ pain			Bronchitis			**Blood disorders**			**Hyperthyroidism**		
Trouble swallowing			Difficult breathing			Blood transfusion			**Arthritis**		
Bloating			Chronic cough			DVT/ Blood clot			**Crohn's Disease**		
Endocrine/Metabolic			Hoarseness			**Skin**			**Ulcerative Colitis**		
Fatigue			**Genitourinary**			Rash			**IBS/ Spastic colon**		
Excessive fluid intake			Painful urination			Bruises			**Colon Polyps**		
Hair change			Frequent urination			Tattoos			**Pancreatitis**		
Heat intolerance			Discharge			**Psychosocial**			**Liver Disease**		
Ear, Nose & Throat			Abnormal menses (fem)			Alcoholism			**Gallstone Disease**		
Earache			**Constitutional**			Substance abuse			**Cancer type**		
Nosebleed			Fever			Depression			**Others list below:**		
			Weight loss			Anxiety disorder					

PAST HISTORY

Please explain any YES answers in detailed description in the box provided

Have you ever had any surgery or been hospitalized?	**No**	**Yes**	**Surgeries**	**Dates**	**Hospitalization other than surgery**	**Dates**
Have you had any problems with anesthesia?	**No**	**Yes**				

Are you currently or have you ever used any tobacco or alcohol products?	**No**	**Yes**	**Alcohol:** How many drinks: per day _____ week _____ month _____ **Tobacco:** How many packs per day _____ week _____ month _____
Are you or have you ever used recreational or illicit drugs?	**No**	**Yes**	If yes what kind? For how long?

Are you currently taking any medication or drugs (including over-the -counter, prescription, birth control pills)?	**No**	**Yes**	**Medication**	**Dose**	**Times**	**Medication**	**Dose**	**Times**

Do you have any allergies (including environmental, medication, food and reaction to previous blood transfusion)?	**No**	**Yes**	**List Allergies:**

FAMILY HISTORY:

Please indicate if your parents, brothers, sisters and /or children have had any of the following conditions.

Condition	Relation to patient	Condition	Relation to patient	Condition	Relation to patient
Colon/Rectal Cancer No _____ Yes _____		Crohn's / UC No _____ Yes _____		Heart disease No _____ Yes _____	
Stomach Ca No _____ Yes _____		Renal disease No _____ Yes _____		Diabetes Mellitus No _____ Yes _____	
Colon Polyps No _____ Yes _____		Breast/Ovary Cancer No _____ Yes _____		Liver cirrhosis No _____ Yes _____	

Patients Signature **Reviewed by Provider** **Date**