

All Patients: please complete pages 1,2 & 3 and SIGN page 3

Last Name	First Name	Date of Birth	Today's Date

Circle the number of years of formal education you have completed

8	9	10	11	12	13	14	15	16	>16
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Please circle the term that best describes your current employment status & describe

Employed	Describe:
Retired	Previous Job:
Unemployed	Previous Job:
Student	Where?

Please state in one or two sentences any current concerns you have

Please list all previous operations with approximate dates. Circle None if appropriate.

1) None	6)
2)	7)
3)	8)
4)	9)
5)	10)

Please check the boxes next to all illnesses you have or have had.

- | | | | | |
|-------------------------------------------------|-------------------------------------------|----------------------------------------------|--------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Asthma | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Esophagitis | <input type="checkbox"/> Excessive Alcohol Use |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Liver Cirrhosis | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cancer: Colon | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Cancer: Esophagus | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Lactose Intolerance | <input type="checkbox"/> Cancer: Stomach | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Cancer: Pancreas | <input type="checkbox"/> Migraine Headache |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Cancer: Prostate | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Sprue | <input type="checkbox"/> Cancer: Breast | <input type="checkbox"/> Arthritis |

List any other illnesses. Circle None if appropriate.

1) None	4)
2)	5)
3)	6)

Please list any family members who have had any of the following problems.

Disease	Relation to you	Disease	Relation to you
Cancer: Colon		Colon Polyps	
Cancer: Breast		Colitis	
Cancer: Prostate		Bleeding Problems	
Cancer: Other:		Liver Disease (cirrhosis)	
Obesity		Alcohol Abuse	
Diabetes		Hepatitis	
Hypertension		Osteoporosis	
Heart Disease		Other:	
High Cholesterol		Other:	

List all your medications (including aspirin & laxatives). Circle None if appropriate

Name of Drug	Dose? (e.g. mg.)	How Often?
None		
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		

List all your medication allergies. If none are known, circle None.

None	3)	6)
1)	4)	7)
2)	5)	8)

Describe your use of the following: Circle None if appropriate.

Tobacco Use	None	___ Packs per day for ___ years	Stopped ___ years ago
Alcohol Use	None	Amount:	Stopped ___ years ago
Illegal Drug Use	None	Type & Amount:	Stopped ___ years ago
Coffee/tea	None	8 oz. cups per day:	
Seat belt use	Always	Describe:	
Exercise	None	Describe:	

Please circle your answer:

Have you been vaccinated against hepatitis B?	Yes - No - Don't Know
Date of last colonoscopy (if over age 50)	Year ___ - Never - Don't Know
Date of last Mammogram (if female)	Year ___ - Never - Don't Know
Date of last Tetanus Vaccination	Year ___ - Never - Don't Know
Date of last Pneumonia Vaccination	Year ___ - Never - Don't Know
Date of last Bone Density Test (for osteoporosis)	Year ___ - Never - Don't Know

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Please indicate whether you experience these symptoms. Circle yes or no.

Symptoms	Yes	No	Physician Comment
Lack of energy	Yes	No	Constitutional
Trouble sleeping	Yes	No	
Weight Loss (10 lbs in 1 yr)	Yes	No	
Weight gain (10 lbs in 1 yr)	Yes	No	
Fevers	Yes	No	
Hard or infrequent bowel movements	Yes	No	GI
Loose or frequent bowel movements	Yes	No	
Blood in bowel movements	Yes	No	
Vomit blood	Yes	No	
Heartburn/Indigestion	Yes	No	
Food sticks when swallowing	Yes	No	Cardiovascular
Painful swallowing	Yes	No	
Yellow jaundice	Yes	No	
Chest pain	Yes	No	
Irregular heartbeat	Yes	No	
Palpitations	Yes	No	Respiratory
Swollen legs	Yes	No	
Fainting	Yes	No	
Shortness of breath	Yes	No	
Wheezing	Yes	No	
Coughing up blood	Yes	No	GU
Asthma	Yes	No	
Frequent urination	Yes	No	
Blood in urine	Yes	No	
Difficulty urinating	Yes	No	
Could you be pregnant	Yes	No	Musculoskeletal
Painful menses	Yes	No	
Joint swelling	Yes	No	
Joint redness	Yes	No	
Gout	Yes	No	
Muscle aches	Yes	No	Breast/Skin
Breast lump	Yes	No	
Unusual or new rash	Yes	No	Neuro
Paralysis	Yes	No	
Stroke	Yes	No	
Seizures	Yes	No	Psychological
Loss of memory	Yes	No	
Depression	Yes	No	
Suicide attempts	Yes	No	Endocrine
Anxiety	Yes	No	
Diabetes	Yes	No	Hemo
Excessive thirst	Yes	No	
Bleeding	Yes	No	Allergy
Easy bruising	Yes	No	
Allergy to shellfish	Yes	No	
Allergy to X-ray dye	Yes	No	

Patient's Signature: _____ Date _____

