

**NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**REFERRING M.D. (name and address):** \_\_\_\_\_  
\_\_\_\_\_

**CHIEF COMPLAINT** (Describe in your own words the symptom(s) leading to this appointment):

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

**PAST MEDICAL HISTORY** (list your illnesses and surgeries, including the year):

<b>Medical Illnesses</b> (i.e. diabetes, high BP, chol):	<b>Surgeries</b> (i.e. appendectomy, hysterectomy):
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**ALLERGIES** (include type of reaction): \_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS** (include dose and frequency; also include over the counter and herbal medications):

_____	_____
_____	_____
_____	_____
_____	_____

**SOCIAL HISTORY:**

Occupation (current or former, retired, disability, etc.): \_\_\_\_\_

Marital Status: \_\_\_\_\_

Number of children (gender/age): \_\_\_\_\_

Tobacco Use (how much, how long, when did you stop): \_\_\_\_\_

Alcohol Use (please be specific): \_\_\_\_\_

Family Member	Age	(alive?)	Medical Problems
Father	_____	(y / n)	_____
Mother	_____	(y / n)	_____
Siblings	_____	(y / n)	_____
	_____	(y / n)	_____
	_____	(y / n)	_____
	_____	(y / n)	_____

(Please circle, if applicable) Family History of colon polyps, colon cancer, ulcerative colitis, Crohn's disease, celiac disease, or cancer (stomach, esophageal, pancreatic, liver, breast, or ovarian)? If yes to any of the above, who and at what age? \_\_\_\_\_

<b>REVIEW OF SYSTEMS</b> (Please circle as applicable):	
<b>Constitutional</b>	weight loss / gain    loss of appetite    fevers    fatigue
<b>Eyes</b>	eye pain    blurry vision    eye redness
<b>ENMT</b>	hearing loss    sinus congestion    sore throat    hoarseness    mouth lesions / ulcers
<b>Allergic</b>	sneezing    runny nose    postnasal drip
<b>Respiratory</b>	cough    wheezing    shortness of breath
<b>Cardiovascular</b>	chest pain    palpitations    irregular heartbeat
<b>Gastrointestinal</b>	heartburn    nausea    vomiting    difficulty swallowing (solids / liquids) pain on swallowing    abdominal pain    diarrhea    constipation blood in stools    stool accidents/incontinence
<b>Genitourinary</b>	blood in urine    pain with urination    frequent urination    nocturnal urination    urinary accidents/ incontinence Women:    irregular/painful menstrual periods    heavy menstrual periods
<b>Musculoskeletal</b>	muscle pains    joint swelling    joint pains    back pain
<b>Neurologic</b>	numbness / tingling    weakness    headache    dizziness    loss of consciousness
<b>Skin</b>	itchiness    redness    rash    hives
<b>Endocrine</b>	heat intolerance    cold intolerance    excessive thirst
<b>Hematologic</b>	easy bleeding    easy bruising
<b>Psychiatric</b>	depression    anxiety    insomnia    excessive stress