NAME____ DATE________________

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:(Including dosage & frequency)

1.______________________________ 2.______________________________

3.______________________________ 4.______________________________

5.______________________________ 6.______________________________

LIST ALLERGIES TO MEDICINES:______________________________

ARE YOU ALLERGIC TO LATEX, IODINE OR X-RAY? Y N

HAVE YOU EVER HAD A COLONOSCOPY? Y N WHEN WAS MOST RECENT?____________

CIRCLE YES OR NO IF YOU HAVE HAD ANY OF THE FOLLOWING:

High Blood Pressure	Y N	Heart Trouble	Y N	Bleeding Problems	Y N	Kidney Disorders	Y N
Colon Disorders	Y N	Diabetes	Y N	Stroke	Y N	HIV/AIDS	Y N
Heart Murmur	Y N	Cancer	Y N	Other Illnesses______________________________			

PLEASE LIST PAST SURGERIES, HOSPITALIZATIONS OR INJURIES:

Operations/Illness	Date	Physician/Hospital

CHILD BIRTH INFORMATION:

List dates and types of delivery (vaginal delivery or c-section):______________________________

____

FAMILY HISTORY:

Please list any medical problems in your relatives:

Father______________________________ Mother______________________________

Siblings______________________________

Children______________________________

SOCIAL HISTORY:

Tobacco Use	☐ Never	☐ Quit/when____________		☐ Current/packs per day________
Alcohol Use	☐ Never	☐ Rarely	☐ Moderate	☐ Daily How much?__________
Drug Use	☐ Never	☐ Past History/Quit when?_________Type?_________		☐ Current Drug User

REVIEW OF SYSTEMS: Please circle:

☐ **Constitutional**
- Good General Health Y N
- Recent weight change Y N
- Night sweats, fevers Y N
- Fatigue/Weakness Y N

☐ **ENT**
- Hearing loss or ringing Y N
- Sinus problems Y N
- Nose bleeds Y N
- Sore throat Y N

☐ **Eyes**
- Wear glasses/contacts Y N
- Blurred/Double vision Y N
- Eye disease or injury Y N
- Glaucoma Y N

☐ **Respiratory**
- Shortness of breath Y N
- Cough Y N
- Wheezing/Asthma Y N
- Coughing up blood Y N

☐ **Cardiovascular**
- Chest pain Y N
- Palpitations Y N
- Heart trouble Y N
- Swelling hands/feet Y N

☐ **Musculoskeletal**
- Muscle pain or cramps Y N
- Stiffness/swelling joints Y N
- Joint Pain Y N
- Trouble walking Y N

☐ **Neurological**
- Frequent headache Y N
- Paralysis or tremors Y N
- Convulsions/seizures Y N
- Numbness/tingling Y N

☐ **Endocrine**
- Excessive thirst/ urination Y N
- Thyroid disease Y N
- Hormone problem Y N

☐ **Integumentary(Skin&Breast)**
- Change in hair or nails Y N
- Rashes or itching Y N
- Breast lump Y N
- Breast pain/discharge Y N

☐ **Hematologic/Lymphatic**
- Bruise easily Y N
- Slow to heal Y N
- Enlarged glands Y N

☐ **Psychiatric**
- Insomnia Y N
- Confusion/memory loss Y N
- Depression Y N

☐ **Genitourinary**
- Blood in urine Y N
- Kidney stones Y N
- Testicle pain Y N
- Menstrual pain Y N

☐ **Gastrointestinal**

Nausea/vomiting	Y N	How long?_____	Rectal Bleeding	Y N	How long?_____	Constipation/diarrhea	Y N
Abdominal Pain	Y N	How long?_____	Pain w/bowel movement	Y N	How long?_____	How long?________	
Diarrhea	Y N	How long?_____	Unable to control gas	Y N	How long?_____	Awakened by rectal pain	Y N
Rectal burning	Y N	How long?_____	Unable to control BM	Y N	How long?_____	How long?________	