



Name: _____

DOB: _____ Age _____

Today's Date _____

Reason for Visit: _____

Past Medical History:

Have you ever had any problems with any of the following?

(Check all boxes that apply or write in any not listed):

- | | | | |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Coronary Blockages | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Irregular Heart Rhythm | <input type="checkbox"/> Artificial Valve | <input type="checkbox"/> Bypass |
| <input type="checkbox"/> Stent / Angioplasty | <input type="checkbox"/> Irregular Heart Rhythm | <input type="checkbox"/> Artificial Valve | <input type="checkbox"/> Bypass |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Home Oxygen | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Kidney dialysis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> HIV | <input type="checkbox"/> Cancer | |

Other (Please describe) _____

Prior Surgical History (list all operations)

Family History (include relation if applicable): Do you have any of the following?

- Colon Polyps: Colon Cancer: Other types of Cancer, Ulcerative Colitis
 Crohn's disease, Liver Disease, Other GI disease.

Please list all of your Medications (including over-the-counter drugs, vitamins, & supplements):

Do you take any Blood Thinner Treatment: Coumadin/Warfarin Plavix Other

Do you have any allergies to medications, latex or IV dye?

No Yes: _____
 Any previous reactions to anesthesia: _____

Do you smoke? Yes No - # of packs per day: ____ # of years smoked: ____
 Quit? No Yes
 Do you use alcohol? No Yes # of drinks per week: ____
 History of excessive alcohol use:

Occupation: _____
 Marital Status: S M D W

Constitutional			Gastrointestinal		
Recent weight change	No	Yes	Poor appetite	No	Yes
Fever	No	Yes	Swallowing difficulty	No	Yes
Fatigue	No	Yes	Heartburn/reflux	No	Yes
Poor Appetite	No	Yes	Nausea/Vomiting	No	Yes
Eyes	No	Yes	Bloating	No	Yes
Vision changes	No	Yes	Belching	No	Yes
Glaucoma	No	Yes	Constipation	No	Yes
Ears/Nose/Mouth/Throat			Abdominal pain	No	Yes
Hearing loss	No	Yes	Recent change in bowel habits	No	Yes
ringing in the ears	No	Yes	Blood in stools	No	Yes
Mouth sores	No	Yes	Black, tarry stools	No	Yes
Chest pain	No	Yes	Neurological		
Shortness of breath	No	Yes	Headaches	No	Yes
Strokes	No	Yes	Seizures	No	Yes
Respiratory			Numbness	No	Yes
Chronic cough	No	Yes		No	Yes

How did you hear about us? Healthcare Provider Referral Friend/Family
 Internet Search / MarylandColonoscopy.com Other: _____

Patient Signature _____ Date _____