

GASTROENTEROLOGY, LTD.
COLON CANCER PREVENTION AND ENDOSCOPY CENTER OF VIRGINIA BEACH
Patient History Form

Name: _____ Date: _____

Date of Birth: _____ Ht: _____ Wt: _____ Date Revised: _____ Initials: _____

Referring Physician: _____ Date Revised: _____ Initials: _____

Date Revised: _____ Initials: _____

Reason for visit: _____

PLEASE LIST ALL ALLERGIES AND REACTION including medications, food, and environmental:

NO ALLERGIES:

Allergy	Reaction	Allergy	Reaction
(1)		(3)	
(2)		(4)	

Review of Systems: Please check (✓) any conditions that currently represent a SIGNIFICANT problem.

GASTROINTESTINAL			
	Yes (✓)		Yes (✓)
Abdominal pain		Diarrhea	
Nausea and vomiting		Constipation	
Heartburn or indigestion		Rectal pain	
Loss of appetite		Rectal bleeding	
Trouble swallowing		Blood in stool	
Hemorrhoids		Tarry stools	

General	Yes (✓)	Cardiovascular	Yes (✓)	Musculoskeletal	Yes (✓)
Fever or chills		Chest pain		Back pain	
Night sweats		Heart palpitations		Leg pain	
Recent weight changes		Irregular heart beat		Muscle weakness	
Ears, Nose, Mouth		Feet or ankle swelling		Neurologic	
Nose bleeds		Genitourinary		Numbness	
Sinus problems		Painful urination		Headaches	
Earache		Urgency		Dizziness	
Dentures		Slow or small stream		Skin	
Hearing loss		Leaking of urine		Rash, dryness, itching	
Pulmonary		Menstrual problems		Jaundice	
Chronic cough, wheezing		Endocrine		Easy bruising	
Shortness of breath		Heat or cold intolerance		Pigment changes	
		Hot flashes		Psychiatric	
		Excessive thirst		Depression	
		Flushing		Anxiety	
				Other	

Patient History Form (cont.)

Please list your medications, the dosage and how often you take each. Include over-the-counter medications as well as herbal products.

NO MEDICATIONS:

	Name of Medication	Dose	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Patient History Form (cont.)

Past Medical History: Please check (✓) any conditions that you have been diagnosed with and/or are currently being treated for:

Pulmonary History	(✓)	General Medical History	(✓)	GI History	(✓)
Asthma		Anemia		Abdominal pain	
Bronchitis		Anesthesia reaction		Change in bowel habits	
Chronic cough		Diabetes		Ulcerative colitis	
COPD		Exposure to communicable disease		Diarrhea	
Difficult to intubate		Glaucoma		Diverticulosis	
Emphysema		Recent treatment for infection		Diverticulitis	
Sleep apnea		Metabolic disorder		Hiatal hernia	
Shortness of breath		MRSA		Jaundice	
TB		Blood transfusion?		Prostate disease	
Cardiac History		Date		Colon polyps	
AICD		Thyroid disease		Celiac disease	
Arrhythmia		Transplant		Constipation	
Chest pain		GU History		Crohn's disease	
Heart disease		Dialysis		Frequent UTI	
Heart failure		Frequent UTI		GI ulcers	
Hypertension		Kidney disease		Hemorrhoids	
Heart attack		Kidney stones		Hepatitis	
Mitral valve prolapse				Rectal bleeding	
Pacemaker				Reflux/Heartburn	
Heart murmur				Varices	
Blood Disorder History				Pancreatic disease	
DIC/Blood clotting disorder				Cirrhosis of the liver	
Excessive bleeding				Gallbladder disease	
Sickle cell				Gallstones	
Cancer History				Neuromuscular History	
Colon cancer				Arthritis	
Other GI cancer: Specify:				Back pain	
Ovarian cancer				Headaches	
Endometrial cancer				Hip fracture	
Prostate cancer				Joint replacement	
Pancreatic cancer				Leg pain	
				Muscle weakness	
				Seizures	
				Stroke	

Other Medical History: _____

Date of Last Hepatitis A Vaccine: _____

Hepatitis B Vaccine _____

Family History: Please check (✓) any family history and indicate which relative.

	✓	Relative		✓	Relative
Colon polyps			Celiac disease		
Colon cancer			Gallbladder disease/gallstones		
Endometrial cancer			Liver disease		
Ovarian cancer			Crohn's disease		
Pancreatic cancer			Ulcerative colitis		

(ONE MORE PAGE...PLEASE CONTINUE!)

