PATIENT HISTORY FORM REVIEW OF SYSTEMS

Name: ______________________________ Date of Birth: __________________

Constitutional
Recent Weight Change ___YES ___NO
Fever ___YES ___NO
Fatigue ___YES ___NO

Eyes
Blurred Vision ___YES ___NO
Glaucoma ___YES ___NO

Ears/Nose/Mouth/Throat
Hearing Loss ___YES ___NO
Ringing in Ears ___YES ___NO
Mouth Sores ___YES ___NO

Cardiovascular
Chest Pain ___YES ___NO
Shortness of Breath ___YES ___NO
Swelling of Ankles ___YES ___NO

Respiratory
Chronic Cough ___YES ___NO
Spitting up Blood ___YES ___NO
Wheezing ___YES ___NO

Genitourinary
Burning with Urination ___YES ___NO
Blood in Urine ___YES ___NO

Musculoskeletal
Joint Pain ___YES ___NO
Swelling ___YES ___NO
Back Pain ___YES ___NO
Muscle Pain ___YES ___NO

Skin
Rash ___YES ___NO
Itching ___YES ___NO

Gastrointestinal
Poor Appetite ___YES ___NO
Difficulty in Swallowing ___YES ___NO
Heartburn ___YES ___NO
Nausea ___YES ___NO
Vomiting ___YES ___NO
Bloating ___YES ___NO
Belching ___YES ___NO
Regurgitation ___YES ___NO
Constipation ___YES ___NO
Diarrhea ___YES ___NO
Abdominal Pain ___YES ___NO
Recent Change in Bowel Habits ___YES ___NO
Rectal Bleeding ___YES ___NO
Black, Tarry Stools ___YES ___NO

Neurological
Headaches ___YES ___NO
Seizures ___YES ___NO
Numbness ___YES ___NO
Strokes ___YES ___NO

Psychiatric
Memory Loss or Confusion ___YES ___NO
Depression ___YES ___NO

Endocrine
Heat Intolerance ___YES ___NO
Cold Intolerance ___YES ___NO
Excessive Thirst ___YES ___NO
Excessive Urination ___YES ___NO

Hematological
Bleeding Tendency ___YES ___NO
Bruising Tendency ___YES ___NO
Past transfusion ___YES ___NO
Anemia ___YES ___NO
Are you Pregnant? ___YES ___NO

Do you take any blood thinners? No ☐ Yes ☐ What Medication ______________________________

Medication Allergies: ____

List of Medications and Doses:

____

____

____

____

Comments/Concerns:

____

PATIENT HISTORY FORM

Name ______________________ Date of Birth________________

Race: White Asian African American Native Hawaiian/Other Pacific Islander American Indian/Alaskian Native

Ethnicity: Hispanic/Latino Non Hispanic/Latino Language: _____________ Height: _______ Weight: ____

Primary Care Physician: ________________Pharmacy: ______________ Location: ________________

Reason for today's visit: ____

List all prior surgeries and date: ____

____

Circle Present and Past Medical History:

Anemia Angina Anxiety Arrhythmia Arthritis Asthma Blood Clot in Leg or Lung Bronchitis Cancer Congestive Heart Failure Constipation Crohn's Disease Depression Diabetes Elevated Cholesterol Emphysema Heart Attack Heart Murmur Hepatitis Hiatal Hernia Hypertension Irritable Bowel Syndrome Peptic Ulcer Reflux Rheumatic Fever Seizure Sleep Apnea Stroke Thyroid Disease Tuberculosis Ulcerative Colitis

Other:____

Have you [1]ever had a colonoscopy before?

☐ No ☐ Yes

If so, when and where? ____________

Have you ever had any problems with anesthesia or sedation? ☐ No ☐ Yes

If yes, what happened? ______________

Have you ever smoked? ☐ No ☐Yes

If currently smoking, how many packs per day? _____

If not currently smoking, quit date: __________

Do you drink alcohol? ☐None ☐Occasional ☐Daily

Recreational drug use? ☐ No ☐ Yes

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed

Do you work? ☐ No ☐ Yes Type of Work: _________

Any family history of liver disease, celiac disease, Crohn's, ulcerative colitis, other cancer? ___________________

Family History Colon Polyps: ☐ No ☐ Yes Whom: _________________

Family History Colon Cancer: ☐ No ☐ Yes Whom: _________________

Family History of Other Significant Disease(s):____

To Be Completed by Gastroenterologist on day of exam:

HPI:____

____

____

____

____

____

Physical Examination: BP_____ Hgt_____ Wgt_____	**Yes**	**No**	**Comments**
1. Constitutional: Well-nourished/well developed:	☐	☐	____________
2. Skin: Skin free of rashes, purpura, petechiae, stigmata:	☐	☐	____________
3. Eyes: Lids and Conjunctivae normal:	☐	☐	____________
4. Ears/Nose/Mouth/Throat: Is the oral mucosa pink/moist	☐	☐	____________
5. Hematologic/Lymphatic/Immunologic: Nodes in neck nl:	☐	☐	____________
6. Respiratory: Lungs clear to auscultation:	☐	☐	____________
7. Cardiovascular: Heart rate regular & no murmur:	☐	☐	____________
8. Gastrointestinal: Soft, nl tympany, active bs, no hsm no masses, no tenderness	☐	☐	____________
9. Musculoskeletal: No clubbing, deformities, edema of extremities	☐	☐	____________
10. Rectal: Hem occult negative:	☐	☐	____________
11. Neurologic: Intact	☐	☐	____________
12. Psychiatric: Alert, oriented to time/person/place	☐	☐	____________

Reviewed By________________________________ Date: ______________

ASA: ________

I have reassessed the patient and find no changes to the above

Reviewed By: _________________________ Date: ____________________