

Patient Name: _____ Age: _____ Date of Visit: _____

Referring MD _____ Cardiologist _____

Primary care physician _____ OB/GYN _____

Gastroenterologist _____ Other MD _____

CHIEF COMPLAINT (the main reason for your visit) _____

List any past MEDICAL PROBLEMS:

- 1. _____ 5. _____
- 2. _____ 6. _____
- 3. _____ 7. _____
- 4. _____ 8. _____

List MEDICATIONS you are currently taking:

- 1. _____ 5. _____
- 2. _____ 6. _____
- 3. _____ 7. _____
- 4. _____ 8. _____

Do you take: Aspirin, Coumadin (warfarin), Plavix (clopidogrel), Ticlid, ibuprophen (i.e. Motrin Advil), Persantine (dipyridamole)

I do not take any of the listed or other blood thinners.

List any prior SURGERIES: Date of Surgery:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

List ALLERGIES to Medications: Type of Reaction:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Have you had a colonoscopy or barium enema before: No Yes

If yes, which physician performed the examination: _____ Date performed: _____

Findings (circle any that apply) polyps, colitis, hemorrhoids, other: _____

FAMILY MEDICAL HISTORY:

Do any of your relatives have Colon Cancer, polyps, Ulcerative Colitis or Crohn's disease? No Yes

If yes, list each member, how they are related and the age they were diagnosed: _____

Do any relatives have any medical conditions (Diabetes, Heart disease, Hypertension, Stroke, seizures, other cancers)? No Yes

If yes, list each member, how they are related and the age they were diagnosed with such conditions: _____

SOCIAL HISTORY:

What is your current profession? _____ Marital Status? Married Divorced Single Widowed

Do you use tobacco? No Yes, How many packs/day _____ Do you drink alcohol? No Yes, How many drinks/week _____

Do you use a controlled substance? No Yes, Which ones? _____

REVIEW OF SYSTEMS (Please further describe any symptoms below):

General	<input type="checkbox"/> No <input type="checkbox"/> Yes Weight loss, how much _____	Gastrointestinal	<input type="checkbox"/> No <input type="checkbox"/> Yes Bowel habit change	Eyes	<input type="checkbox"/> No <input type="checkbox"/> Yes Changes in vision
	<input type="checkbox"/> No <input type="checkbox"/> Yes Recurrent fever		<input type="checkbox"/> No <input type="checkbox"/> Yes Bleeding		<input type="checkbox"/> No <input type="checkbox"/> Yes Cataracts
Ears, Nose and Throat	<input type="checkbox"/> No <input type="checkbox"/> Yes Dental problems		<input type="checkbox"/> No <input type="checkbox"/> Yes Abdominal pain	Neurologic	<input type="checkbox"/> No <input type="checkbox"/> Yes /Glaucoma
	<input type="checkbox"/> No <input type="checkbox"/> Yes Bleeding Gums		<input type="checkbox"/> No <input type="checkbox"/> Yes Constipation		<input type="checkbox"/> No <input type="checkbox"/> Yes Stroke/Seizure
Cardiovascular	<input type="checkbox"/> No <input type="checkbox"/> Yes Difficulty swallowing		<input type="checkbox"/> No <input type="checkbox"/> Yes Diarrhea		<input type="checkbox"/> No <input type="checkbox"/> Yes Fainting/ blackouts
	<input type="checkbox"/> No <input type="checkbox"/> Yes High blood pressure		<input type="checkbox"/> No <input type="checkbox"/> Yes Nausea or vomiting		<input type="checkbox"/> No <input type="checkbox"/> Yes Loss of function
	<input type="checkbox"/> No <input type="checkbox"/> Yes Chest pain/Heart attack	Endocrine	<input type="checkbox"/> No <input type="checkbox"/> Yes Peptic ulcer disease	Oncologic	<input type="checkbox"/> No <input type="checkbox"/> Yes Chemotherapy
	<input type="checkbox"/> No <input type="checkbox"/> Yes Irregular heart beat		<input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes		<input type="checkbox"/> No <input type="checkbox"/> Yes Radiation
	<input type="checkbox"/> No <input type="checkbox"/> Yes Palpitations	Genitourinary	<input type="checkbox"/> No <input type="checkbox"/> Yes Thyroid problems	Psychiatric	<input type="checkbox"/> No <input type="checkbox"/> Yes Anxiety/Mood swings
	<input type="checkbox"/> No <input type="checkbox"/> Yes Swollen feet		<input type="checkbox"/> No <input type="checkbox"/> Yes Steroid use		<input type="checkbox"/> No <input type="checkbox"/> Yes Depression
	<input type="checkbox"/> No <input type="checkbox"/> Yes Abnormal stress test		<input type="checkbox"/> No <input type="checkbox"/> Yes Painful urination		<input type="checkbox"/> No <input type="checkbox"/> Yes Joint pain
	<input type="checkbox"/> No <input type="checkbox"/> Yes Pacemaker		<input type="checkbox"/> No <input type="checkbox"/> Yes Blood in urine		<input type="checkbox"/> No <input type="checkbox"/> Yes /Arthritis
	<input type="checkbox"/> No <input type="checkbox"/> Yes Heart murmur		<input type="checkbox"/> No <input type="checkbox"/> Yes Urinary incontinence	HIV	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Tested
	<input type="checkbox"/> No <input type="checkbox"/> Yes Heart murmur		<input type="checkbox"/> No <input type="checkbox"/> Yes Urinary frequency		Additional Comments:
Respiratory	<input type="checkbox"/> No <input type="checkbox"/> Yes Abnormal heart valve	Dermatologic	<input type="checkbox"/> No <input type="checkbox"/> Yes Rash/Ulcer		
	<input type="checkbox"/> No <input type="checkbox"/> Yes High cholesterol		<input type="checkbox"/> No <input type="checkbox"/> Yes Easy Bruising		
	<input type="checkbox"/> No <input type="checkbox"/> Yes Shortness of breath		<input type="checkbox"/> No <input type="checkbox"/> Yes Skin Cancer		
	<input type="checkbox"/> No <input type="checkbox"/> Yes Emphysema		<input type="checkbox"/> No <input type="checkbox"/> Yes Anemia		
	<input type="checkbox"/> No <input type="checkbox"/> Yes Cough with sputum	Hematologic	<input type="checkbox"/> No <input type="checkbox"/> Yes Bleeding disorder		
	<input type="checkbox"/> No <input type="checkbox"/> Yes Asthma				

I have reviewed the above review of systems with the patient today: _____