



## HISTORY FORM

**Please complete this form so we can better meet your needs:**

Your Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Your Occupation: \_\_\_\_\_

**Family History:** Do you have a family member who has or had any of the following:

Colorectal Cancer: Yes \_\_\_ No \_\_\_ Who? \_\_\_\_\_

Other Cancer: Yes \_\_\_ No \_\_\_ Who? \_\_\_\_\_ Type of Cancer: \_\_\_\_\_

Polyps: Yes \_\_\_ No \_\_\_ Who? \_\_\_\_\_

Ulcer: Yes \_\_\_ No \_\_\_ Who? \_\_\_\_\_

Liver Disease: Yes \_\_\_ No \_\_\_ Who? \_\_\_\_\_

Pancreatitis: Yes \_\_\_ No \_\_\_ Who? \_\_\_\_\_

Gallbladder Disease: Yes \_\_\_ No \_\_\_ Who? \_\_\_\_\_

Crohn's Disease: Yes \_\_\_ No \_\_\_ Who? \_\_\_\_\_

Ulcerative Colitis: Yes \_\_\_ No \_\_\_ Who? \_\_\_\_\_

**Your History:**

Do you have any other medical problems? (**high blood pressure, diabetes, arthritis, heart disease, etc**)

\_\_\_\_\_

Please list all the surgeries and hospitalizations you have had:

year

year

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list all your medicines (include prescriptions, over the counter medications and vitamins).

Do you take aspirin, arthritic or pain medications?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any allergies? (medications, foods, dyes or latex) If so, please list:

\_\_\_\_\_

\_\_\_\_\_

Do you smoke? **Y N**

Number of packs per day \_\_\_\_\_ Number of years you have smoked \_\_\_\_\_

Do you use alcohol? **Y N**

Number of drinks per week \_\_\_\_\_

Do you drink coffee/tea/caffeinated soft drinks? **Y N**



Your Name: \_\_\_\_\_

Why are you here today? \_\_\_\_\_

**Please answer the following questions by placing a checkmark by the “yes” or “no”**

**Have you:**

- Been in good health lately? Yes \_\_\_ No \_\_\_
- Had any recent weight changes? Yes \_\_\_ No \_\_\_
- Had a fever? Yes \_\_\_ No \_\_\_
- Felt fatigued? Yes \_\_\_ No \_\_\_

**Have you had any of the following problems recently?**

- |                               |                |                               |                |
|-------------------------------|----------------|-------------------------------|----------------|
| Eye diseases                  | Yes ___ No ___ | Muscle Pain                   | Yes ___ No ___ |
| Blurred vision                | Yes ___ No ___ | Rash                          | Yes ___ No ___ |
| Hearing loss                  | Yes ___ No ___ | Headaches                     | Yes ___ No ___ |
| Ringling in your ears         | Yes ___ No ___ | Seizures                      | Yes ___ No ___ |
| Mouth sores                   | Yes ___ No ___ | Numbness                      | Yes ___ No ___ |
| Bad taste in your mouth       | Yes ___ No ___ | Weakness                      | Yes ___ No ___ |
| Sore throat                   | Yes ___ No ___ | Confusion                     | Yes ___ No ___ |
| Sore tongue                   | Yes ___ No ___ | Depression                    | Yes ___ No ___ |
| Chest pain                    | Yes ___ No ___ | Heat or Cold Intolerance      | Yes ___ No ___ |
| Shortness of breath           | Yes ___ No ___ | Excessive thirst or urination | Yes ___ No ___ |
| Swelling in your ankles       | Yes ___ No ___ | Bruise easily                 | Yes ___ No ___ |
| A chronic cough               | Yes ___ No ___ | Anemia                        | Yes ___ No ___ |
| Spitting up blood             | Yes ___ No ___ | Phlebitis                     | Yes ___ No ___ |
| Wheezing                      | Yes ___ No ___ | Past blood transfusion        | Yes ___ No ___ |
| Change in appetite            | Yes ___ No ___ | Joint pain                    | Yes ___ No ___ |
| Difficulty swallowing         | Yes ___ No ___ | Irregular periods             | Yes ___ No ___ |
| Heartburn                     | Yes ___ No ___ |                               |                |
| Nausea or 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 ___ |                               |                |
| Burning with urination        | Yes ___ No ___ |                               |                |
| Blood in your urine           | Yes ___ No ___ |                               |                |
| Inability to hold your urine  | Yes ___ No ___ |                               |                |

**For Office use only**

Reviewed: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_