PATIENT MEDICAL HISTORY

Patient Name:____________________________ Date of Birth:______________________

Allergies/Reaction:_________________________ Height:_________ Weight_______

____ Primary Care Physician________________

1. If you are currently experiencing any of these symptoms, please call us to schedule an office visit:

   __Abdominal pain __Change in bowel habits __Diarrhea

   __Constipation __Rectal bleeding __Mucus in stool

   __Loss of appetite __Unintentional weight loss __Heartburn/Reflux

   __Problems swallowing/Food getting stuck __Other

   __NONE OF THE ABOVE

2. Personal Medical History (Please check all that apply and specify)

   __Cardiovascular Disease (MI, CHF, Irregular rhythm, A.Fib) __Hypertension

   __Respiratory Disease (Asthma, COPD, Sleep apnea, use of CPAP)

   __Renal /Kidney Disease

   __Neurological Disease (seizures, stroke)

   __Endocrine Disease (diabetes, thyroid, pituitary, adrenal)

   __Musculoskeletal Disease (arthritis, gout)

   __Psychiatric/Psychological Disease

   __Blood Disorder/Cancer (type)

   __Other_____________________

   __NONE OF THE ABOVE

   LAST PHYSICAL___________ Normal____ Abnormal____

   LAST EKG__________________ Normal____ Abnormal_____

3. Current Medications: (Please list all prescription and over the counter meds)

Mecication Name	Dosage	Medication Name	Dosage
_______________	__________	_______________	_________
_______________	__________	_______________	_________
_______________	__________	_______________	_________
_______________	__________	_______________	_________

4. Social History (Please check all that apply)

   __Tobacco History How much?__________________________

   __Alcohol How much?__________________________

   __Caffeine How much?__________________________

   __Exercise Routine What and how much?_________________

5. Family History (Please check all that apply and indicate family member & age of dx)

   Colon Cancer_______________________ Colon Polyps________________________

   Stomach Cancer_____________________ Esophageal Cancer__________________

   Barrett's Esophagus_________________ Peptic Ulcer Disease _________________

   Crohn's Disease______________________ Ulcerative Colitis____________________

   Gallbladder Disease___________________ Breast or GYN Cancer________________

6. Procedure History (When was your last procedure and what were the results?)
   __Colonscopy ____/____/____ __Normal__Polyps or other________
   __Upper Endoscopy (EGD) ____/____/____ __Normal__Other________
   __Flexible Sigmoidoscopy ____/____/____ __Normal__Other________
   __I have never had any endoscopies

7. Surgical History or Hospitalizations
   __NONE
   ____/____/____ ____
   ____/____/____ ____
   ____/____/____ ____
   ____/____/____ ____

   __Personal or Family History of Problems with Anesthesia_______________________

The medical information provided in this packet is complete and true to my knowledge.

______________________________ ____________
Patient signature Date

FOR OFFICE USE ONLY

1. BMI:______ SLEEP APNEA________ CPAP_______
2. Patient scheduled for procedure? __Yes __No
3. Reason: __CRSC __FHx __H/O Polyps __H/O CRC __Other
4. __Suprep __Prepopik __Moviprep __Other
5. __FOH __RHC __ASC __GCV
6. __MAS __LSF __RAB __SSH __HSS
7. Patient needs office visit for: ______________________________________

MLP Signature ______________________________ **Date** ____________