Medical History Form

Patient Name: _____ **Date of Birth:** _____

Reason for today's visit: _____

Pharmacy: _____

Medical History: Please circle yes or no

Anemia	No	Yes
Anxiety	No	Yes
Arrhythmia	No	Yes
Colitis	No	Yes
Colonoscopy	No	Yes
Colon Polyps	No	Yes
Depression	No	Yes
Diabetes	No	Yes
Diverticulosis	No	Yes
Diverticulitis	No	Yes
COPD	No	Yes
Endometriosis	No	Yes
Endoscopy	No	Yes
Fatty Liver	No	Yes
GERD	No	Yes

Hepatitis Type: _____	No	Yes
Heart Disease	No	Yes
High Blood Pressure	No	Yes
High Cholesterol	No	Yes
Irritable Bowel Disease	No	Yes
Kidney Stones	No	Yes
Kidney Disease	No	Yes
Pancreatitis	No	Yes
Seizures	No	Yes
Sleep Apnea	No	Yes
CPAP BiPAP APAP		
Stroke/TIA	No	Yes
Thyroid Disease	No	Yes

Allergies	Reaction(s)

Current Medications – List all prescription and over the counter medications

Medications	Dosage

Have you ever seen a cardiologist (heart)? ☐ No ☐ Yes Physician/Office: _____

Have you ever seen a hematologist (blood)? ☐ No ☐ Yes Physician/Office: _____

Have you ever seen a nephrologist (kidney)? ☐ No ☐ Yes Physician/Office: _____

Have you ever seen any other specialists? ☐ No ☐ Yes Physician/Office: _____

Social History

Alcohol Use: ☐ None ☐ Yes

Tobacco Use: ☐ Never ☐ Former ☐ Current ☐ E-cigarette

Height: _____ **Weight:** _____

Past Surgical History

Surgical Type	Year

Family Medical History – If yes, please list the relation(s)

Breast Cancer No Yes _____

Colon Cancer No Yes _____

Esophagus No Yes _____

Stomach No Yes _____

Anesthesia Questionnaire:

Any past problems with anesthesia?	No	Yes
Atrial Fibrillation	No	Yes
CABG (Coronary artery bypass graft)	No	Yes
GLP-1	No	Yes
Heart Attack	No	Yes

Do you snore?	No	Yes
Kidney Failure/dialysis	No	Yes
Organ Transplant	No	Yes
Oxygen Therapy	No	Yes
Pacemaker	No	Yes

Are you currently having any of the following symptoms:

Nausea	No	Yes
Vomiting	No	Yes
Heartburn	No	Yes
Bloating	No	Yes
Loss of appetite	No	Yes
Food sticking in throat	No	Yes

Painful swallowing	No	Yes
Hemorrhoids	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Abdominal pain	No	Yes
Blood in stool	No	Yes

GI History

Have you had a previous colonoscopy? ☐ No ☐ Yes Year: _____ Physician: _____

Have you had a previous endoscopy? ☐ No ☐ Yes Year: _____ Physician: _____