MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: _____ Today's Date: _____

Reason for Visit

- ○ Colonoscopy
- ○ Colonoscopy & EGD
- ○ EGD
- ○ Weight Loss
- ○ Consultation

Are you experiencing any of the following? ○ Yes* ○ No

- ○ Diarrhea
- ○ Change in bowel habits
- ○ Blood in stool
- ○ Abdominal pain
- ○ Chronic constipation
- ○ Chest Pain
- ○ Anemia
- ○ Persistent heartburn
- ○ Positive occult stool test
- ○ Rectal bleeding
- ○ Indigestion
- ○ Difficulty swallowing
- ○ Prostate issues
- ○ Positive Cologuard

*If yes, please explain _____

Height:_____ Weight:_____

Allergies – (Are you allergic to any drugs, iodine, shellfish, latex, or any other allergies?)

○ Yes ○ No

Allergies: _____

Reactions: _____

Medication List (Include any vitamins and supplements that you are currently taking)

	Name	Dose	How Often
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Family History

Any family history of colon polyps or colon cancer? Please circle ○ Yes ○ No

Who? _____ Age of Onset? _____

Any family history of stomach, esophageal, or rectal cancer? ○ Yes ○ No

Who? _____ Age of Onset? _____

Social History

Who referred you? _____ Phone number: _____

Have you ever had a colonoscopy or EGD before? ○ Yes ○ No

When? _____ What Physician? _____ Results? _____

Do you have any issues with mobility? I.e. Cane Walker Wheelchair ○ Yes ○ No

*If yes, please explain _____

Are you able to climb two flights of stairs without stopping? ○ Yes ○ No

Do you smoke tobacco? ○ Yes ○ No ○ Quit (When?) _____

How many packs do you smoke per day or per week? _____

Do you drink alcohol? ○ Yes ○ No

How many drinks do you have per day or per week? _____

Are you pregnant or believe that you may be? ○ Yes ○ No

Continued on next page ➡

Surgical History

Procedure	Date
1.	
2.	
3.	
4.	
5.	

Past Medical History – (Answer yes if you ever have been diagnosed with one of the following)

Coronary Artery Disease	○ Yes	○ No
Myocardial Infarction/Heart Attack	○ Yes	○ No
Atrial fibrillation/Arrythmia	○ Yes	○ No
Heart valve replacement	○ Yes	○ No
Pacemaker/Internal defibrillator	○ Yes	○ No
COPD/Asthma/Emphysema/Use at home oxygen	○ Yes	○ No
Stroke	○ Yes	○ No
Seizures/Epilepsy – When_____	○ Yes	○ No
Renal failure/Kidney disease	○ Yes	○ No
Diabetes	○ Yes	○ No
Pulmonary embolus/ DVT / Blood Clot	○ Yes	○ No
Arthritis	○ Yes	○ No
Barrett's esophagus	○ Yes	○ No
Bleeding disorder (difficulty stopping bleeding)	○ Yes	○ No
Cancer – What type? _____When diagnosed? _____	○ Yes	○ No
Chronic constipation	○ Yes	○ No
Colon Polyps	○ Yes	○ No
Exposure to contagious diseases (HIV, TB, Hepatitis B, Hepatitis C)	○ Yes	○ No
Crohn's disease	○ Yes	○ No
Diverticulosis/Diverticulitis	○ Yes	○ No
Endometriosis	○ Yes	○ No
GERD/Reflux (Heartburn)	○ Yes	○ No
Hyperlipidemia (High cholesterol)	○ Yes	○ No
Hypertension (High blood pressure)	○ Yes	○ No
Hyperthyroidism (Overactive thyroid)	○ Yes	○ No
Hypothyroidism (Underactive thyroid)	○ Yes	○ No
Kidney Stones – When _____	○ Yes	○ No
Sleep Apnea	○ Yes	○ No
Ulcerative colitis	○ Yes	○ No

Patient Preferences

Pharmacy: _____ Phone Number:_____
Primary Care Physician: _____ Phone Number: _____
Cardiologist: _____ Phone Number: _____
Endocrinologist: _____ Phone Number: _____
Neurologist: _____ Phone Number: _____
Nephrologist: _____ Phone Number: _____
Pulmonologist: _____ Phone Number: _____
Lab:_____

Any additional questions or concerns?