Patient Name _____

Medications (Please list or indicate **none**) _____

_____

_____

_____

Medicine Allergies (Please list or indicate **none**) _____

_____

Do your blood relatives have:

Colon or rectal cancer? ☐ Yes ☐ No Who? _____

Colon or rectal polyps? ☐ Yes ☐ No Who? _____

Crohn's or Ulcerative Colitis? ☐ Yes ☐ No Who? _____

Do you smoke? ☐ Yes ☐ No How many packs per day? ____

Do you drink coffee? ☐ Yes ☐ No How many cups per day? ____

Do you drink alcohol? ☐ Yes ☐ No ☐ Socially ☐ Rarely ____ Number of drinks per day

Past Surgical History

(Mark all that apply)

- ☐ Appendectomy _____ Year
- ☐ Back Surgery ___ Lower ___ Neck _____ Year
- ☐ Breast biopsy ___ Lt ___ Rt _____ Year
- ☐ Breast, lumpectomy ___ Lt ___ Rt _____ Year
- ☐ Breast, mastectomy ___ Lt ___ Rt _____ Year
- ☐ Cataract Surgery ___ Lt ___ Rt _____ Year
- ☐ Coronary artery heart bypass _____ Year
- ☐ Gallbladder, open _____ Year
- ☐ Gallbladder, laparoscopic _____ Year
- ☐ Hernia ___ Lt ___ Rt ___ Umbilical _____ Year
- ☐ Hysterectomy __ Open __ Laparoscopic __ Vaginal _____ Year
- ☐ Hysterectomy with removal ___ Lt Ovary ___ Rt Ovary
- ☐ Knee Surgery ___ Lt ___ Rt _____ Year
- ☐ Tonsillectomy _____ Year

Other Surgery (Please fill in details)

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Past Medical History

(Mark all that apply)

Bladder Problems

☐ Stress Incontinence ☐ Difficulty urinating

☐ Night time urination ___ times per night

☐ Frequent Infections ☐ Bladder Cancer

Diabetes

☐ Borderline ☐ Diet Controlled

☐ Insulin ☐ On Pills

High Blood Pressure

☐ No Medications ☐ On Medications

Kidney Problems

☐ Kidney Cancer ☐ On Dialysis

Liver Problems

☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C

Heart Problems

☐ Chest Pain

☐ This week ☐ Last month ☐ In last 6 months

☐ Irregular heartbeat ☐ Atrial Fibrillation

☐ Palpitations ☐ Heart Attack in _____ Year

☐ Heart Damage ☐ Heart Surgery ☐ Angioplasty

Shortness of Breath

☐ Asthma ☐ Emphysema ☐ COPD

Stroke

☐ Mild ☐ Severe ☐ No residual problems

Blood Clots

☐ In legs ☐ In arms ☐ Required blood thinners

Duodenal or Stomach Ulcer

☐ In the past ☐ Controlled ☐ Not controlled

Other

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Patient Name _____

Review of Systems

(Mark all that apply)

Constitutional Symptoms:

- ☐ Severe headaches
- ☐ Dizzy spells
- ☐ Fatigue
- ☐ Weakness
- ☐ Marked weight loss
- ☐ Marked weight gain
- ☐ Night sweats
- ☐ Persistent fever
- ☐ Sensitive to heat
- ☐ Sensitive to cold

Eyes:

- ☐ Trouble seeing
- ☐ Eye pain
- ☐ Floaters
- ☐ Inflamed eyes
- ☐ Double vision
- ☐ Cataracts
- ☐ Wear contacts
- ☐ Wear glasses
- ☐ Vision loss
- ☐ Blindness

Ears, Nose, Mouth, and Throat:

- ☐ Loss of hearing
- ☐ Ringing in ears
- ☐ Discharge from ears
- ☐ Dizziness
- ☐ Frequent ear infection
- ☐ Ear tube placement
- ☐ Loss of smell
- ☐ Frequent colds
- ☐ Difficult nasal breathing
- ☐ Nose bleeds
- ☐ Snoring
- ☐ Sore mouth
- ☐ Sore gums
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Dental problems
- ☐ Dentures
- ☐ Tooth ache
- ☐ Postnasal drainage
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Pain with swallowing
- ☐ Neck swelling
- ☐ Neck stiffness
- ☐ Other _____

Breasts (Females only):

- ☐ Lumps
- ☐ Discharge
- ☐ Armpit swelling
- ☐ Fibrocystic disease
- ☐ Breast cancer, personal
- ☐ Breast cancer in family

Heart:

- ☐ Angina
- ☐ Atrial fibrillation
- ☐ Slow heart rate
- ☐ Rapid heart rate
- ☐ Rheumatic fever
- ☐ Palpitations
- ☐ Leg pain when walking
- ☐ Congestive heart failure
- ☐ Ankle swelling
- ☐ Shortness of breath
- ☐ Pacemaker
- ☐ Prior heart arteriogram
- ☐ Heart bypass surgery _____
- ☐ Heart valve surgery
- ☐ Other _____

Lungs:

- ☐ Persistent cough
- ☐ Productive cough
- ☐ Cough up blood
- ☐ Wheezing
- ☐ Pulmonary embolus
- ☐ Blood clots in leg veins
- ☐ History of bronchitis
- ☐ Pneumonia
- ☐ Lung cancer, personal
- ☐ Lung cancer in family
- ☐ Tuberculosis
- ☐ Other _____

Musculoskeletal:

- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Generalized aches
- ☐ Ankle pain
- ☐ Arthritis
- ☐ Back pain
- ☐ Cervical disc disease
- ☐ Elbow pain
- ☐ Lumbar disc disease
- ☐ Joint stiffness
- ☐ Joint swelling
- ☐ Knee pain
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Wrist pain
- ☐ Cramps with walking
- ☐ Leg cramps at night

Gastrointestinal:

- ☐ Constipation
- ☐ Diarrhea
- ☐ Change in bowel habit
- ☐ Gallstones
- ☐ Heartburn
- ☐ Weight loss
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Tar black stools
- ☐ Abdominal pain
- ☐ Jaundice
- ☐ GI Cancer _____
- ☐ Diverticular disease
- ☐ Loss of control of stools
- ☐ Wear a pad for stool leakage
- ☐ Rectal bleeding
- ☐ Anal pain
- ☐ Anal itching
- ☐ Other _____

Patient Name _____

Genitourinary:

- ☐ Prostate trouble (Men only)
- ☐ Prostate cancer (Men only)
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Urinary incontinence
- ☐ Loss of sex drive
- ☐ Kidney disease _____
- ☐ Dialysis
- ☐ Other _____

Gynecologic (Females only)

- ☐ Use birth control pills
- ☐ Taking hormones
- ☐ Irregular periods
- ☐ Heavy periods
- ☐ Painful intercourse
- ☐ Cervical cancer, personal
- ☐ Cervical cancer in family
- ☐ Ovarian cysts
- ☐ Ovarian cancer, personal
- ☐ Ovarian cancer in family
- ☐ Uterine cancer, personal
- ☐ Uterine cancer in family
- ☐ Pelvic infections
- ☐ Uterine fibroids

Skin:

- ☐ Acne
- ☐ Hair loss
- ☐ Change in hair
- ☐ Change in nails
- ☐ New or change in mole
- ☐ Skin ulcers
- ☐ Rash
- ☐ Melanoma, personal
- ☐ Melanoma in family
- ☐ Psoriasis
- ☐ Basal cell carcinoma
- ☐ Squamous carcinoma

Endocrine:

- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Diabetes
- ☐ Goiter
- ☐ Taking thyroid supplement

Neurologic:

- ☐ Dementia
- ☐ Disc problems
- ☐ Dizziness
- ☐ Migraines
- ☐ Multiple sclerosis
- ☐ Passing out
- ☐ Depression
- ☐ Seizures
- ☐ Anxiety
- ☐ Sleeplessness
- ☐ Poor balance
- ☐ Weakness
- ☐ Memory loss
- ☐ Paralysis
- ☐ Parkinsonism
- ☐ Prior stroke
- ☐ TIA
- ☐ Numbness

Infection:

- ☐ HIV+
- ☐ Immunizations Not Up to Date

Blood System:

- ☐ Anemia
- ☐ Bleeding Disorder

Latex Allergy:

- ☐ Yes
- ☐ No