PATIENT NAME______________________________ Birth date _____________ Date________________

ALLERGIES ____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE ALLERGIC TO: __________________

____

ALLERGIC TO: LATEX: NO YES RUBBER: NO YES FOOD: NO YES________________

MEDICAL HOSTORY	Patient	Family	Details
Diabetes	No Yes	No Yes	__________________
Respiratory (breathing problems)	No Yes	No Yes	__________________
High Blood Pressure	No Yes	No Yes	__________________
Heart Attack	No Yes	No Yes	__________________
Congestive Heart Failure	No Yes	No Yes	__________________
Mitral Valve Prolapse	No Yes	No Yes	__________________
Other Heart problems	No Yes	No Yes	__________________
Stroke	No Yes	No Yes	__________________
Aneurysm	No Yes	No Yes	__________________
Cancer	No Yes	No Yes	__________________
Arthritis / Gout	No Yes	No Yes	__________________
Seizures/ Convulsions	No Yes	No Yes	__________________
HIV/ AIDS	No Yes	No Yes	__________________
Bleeding Problems	No Yes	No Yes	__________________
Thyroid Disease	No Yes	No Yes	__________________
Hernia	No Yes	No Yes	__________________
Peptic Ulcer	No Yes	No Yes	__________________
Gall Stones	No Yes	No Yes	__________________
Kidney Stones	No Yes	No Yes	__________________
Varicose Veins	No Yes	No Yes	__________________

Please List Other Medical Conditions if Any: ____

____

____

Please List Any Hospitalization/ Surgeries/ Serious Injuries: __________________________

____

PATIENT NAME ______________________________________

OTHER

If you are age 50 or older, have you ever had a colonoscopy? No Yes

If yes, when _________________ Why? ____

Alcohol Use: Never Rarely Moderately Daily

Tobacco Use: Never Rarely Moderately _____ Packs Daily Quit ________Months/ years ago

Drug Use: Never Type/ Frequency __________________________

ACCIDENTAL INJURY

Is the patient here because of work related injury? No Yes

If Yes, Date of Injury ___________________________

Is the Patient here because of an Auto Accident? No Yes

If Yes, Date of Injury ___________________________