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MEDICAL HISTORY QUESTIONNAIRE

FIRST NAME_____DATE _____

WHY ARE YOU SEEING THE DOCTOR TODAY? _____

DO YOU HAVE AN ADVANCED DIRECTIVE? ☐NO ☐YES (PLEASE PROVIDE A COPY)

IF NOT, WOULD YOU LIKE INFORMATION? ☐NO ☐YES

PLEASE LIST ANY MEDICATIONS AND DOSAGES YOU ARE *CURRENTLY* TAKING (PLEASE LET US KNOW IF YOU ARE TAKING ANY NSAIDS / BLOOD THINNERS (ALEVE, ASPIRIN, IBUPROFEN, PLAVIX, COUMADIN, ETC). *USE BACK OF SHEET IF ADDITIONAL SPACE IS NEEDED.*

DRUG	DOSAGE

DRUG ALLERGIES (PLEASE LIST ANY DRUG ALLERGIES YOU HAVE OR HAD) ☐NO KNOWN ALLERGIES
USE BACK OF SHEET IF ADDITIONAL SPACE IS NEEDED.

DRUG	REACTION

HAVE YOU HAD A COLONOSCOPY? ☐NO ☐YES, WHEN_____

OTHER SURGICAL HISTORY(INDICATE PREVIOUS SURGERIES INCLUDING DATE): ☐NO OTHER SURGERIES

SURGERY / PROCEDURE	DATE

DID YOU HAVE PROBLEMS WITH ANESTHESIA? ☐NO ☐YES, EXPLANATION _____

PAST PERSONAL MEDICAL HISTORY (IFSO, PROVIDE EXPLANATION)

		EXPLANATION			EXPLANATION
ABDOMINAL PAIN	☐ **YES** ☐ **NO**		**HIGH BLOOD PRESSURE**	☐ **YES** ☐ **NO**	
REFLUX	☐ **YES** ☐ **NO**		**SWALLOWING DIFFICULTY**	☐ **YES** ☐ **NO**	
SWELLING	☐ **YES** ☐ **NO**		**ESOPHAGITIS**	☐ **YES** ☐ **NO**	
CELIAC DISEASE	☐ **YES** ☐ **NO**		**GALLSTONES**	☐ **YES** ☐ **NO**	

CIRRHOSIS	□ **YES** □ **NO**		**HEMORROIDES**	□ **YES** □ **NO**	
COLORECTAL CANCER	□ **YES** □ **NO**		**IRRITABLE BOWEL SYNDROME (IBS)**	□ **YES** □ **NO**	
COLON POLYPS	□ **YES** □ **NO**		**NAUSEA / VOMITING**	□ **YES** □ **NO**	
CONSTIPATION	□ **YES** □ **NO**		**PANCREATITIS**	□ **YES** □ **NO**	
DIABETES	□ **YES** □ **NO**		**OTHER CANCERS NOT LISTED**	□ **YES** □ **NO**	
DIARRHEA	□ **YES** □ **NO**		**OTHER SYMPTOMS**	□ **YES** □ **NO**	

DO YOU SMOKE OR CHEW TOBACCO? □NO□YES **IF SO, HOW MUCH?** _____

EX-SMOKER? □NO □YES **WHEN DID YOU QUIT?** _____

DO YOU DRINK ALCOHOL? □NO □YES **IF SO, HOW MUCH AND HOW OFTEN?** _____

FAMILY HISTORY (PLEASE INDICATE RELATIONSHIP)

		RELATIONSHIP			**RELATIONSHIP**
COLORECTAL CANCER	□ **YES** □ **NO**		**HIGH BLOOD PRESSURE**	□ **YES** □ **NO**	
COLON POLYPS	□ **YES** □ **NO**		**ANOTHER TYPE OF CANCER**	□ **YES** □ **NO**	
DIABETES	□ **YES** □ **NO**		**OTHER MEDICAL PROBLEMS**	□ **YES** □ **NO**	
HEART PROBLEMS	□ **YES** □ **NO**				

ADDITIONAL COMMENTS

_____

_____

_____ _____

Signature of Patient or Legal Guardian Date