Advanced
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MEDICAL HISTORY

NAME _____DATE _____

WHY ARE YOU SEEING THE DOCTOR TODAY? _____

DO YOU HAVE AN ADVANCED DIRECTIVE? _____ **(If yes, please provide us with a copy)**

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).

DRUG	DOSAGE

DRUG ALLERGIES (PLEASE LIST ANY DRUG ALLERGIES YOU HAVE OR HAD) _____

DRUG	REACTION

HAVE YOU HAD A COLONOSCOPY ? _____ IF YES WHEN: _____

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

SURGERY / PROCEDURE	DATE

DID YOU HAVE PROBLEMS WITH ANESTHESIA ? _____ IF YES, EXPLAIN _____

PAST PERSONAL MEDICAL HISTORY (IF SO , PROVIDE EXPLANATION)

		EXPLANATION			EXPLANATION
ABDOMINAL PAIN	_____		**HIGH BLOOD PRESSURE**	_____	
REFLUX	_____		**SWALLOWING DIFFICULTY**	_____	
SWELLING	_____		**ESOPHAGITIS**	_____	
CELIAC DISEASE	_____		**GALLSTONES**	_____	
CIRRHOSIS	_____		**HEMORROIDES**	_____	
COLORECTAL CANCER	_____		**IRRITABLE BOWEL SYNDROME (IBS)**	_____	
COLON POLYPS	_____		**NAUSEA / VOMITING**	_____	
CONSTIPATION	_____		**PANCREATITIS**	_____	
DIABETES	_____		**OTHER CANCERS NOT LISTED**	_____	
DIARRHEA	_____		**OTHER SYMPTOMS**	_____	

DO YOU SMOKE OR CHEW TOBACCO? _____ **IF SO, HOW MUCH?** _____

EX-SMOKER? _____ **WHEN DID YOU QUIT?** _____

DO YOU DRINK ALCOHOL? _____ **IF SO, HOW MUCH AND HOW OFTEN?** _____

FAMILY HISTORY (PLEASE INDICATE RELATIONSHIP)

		RELATIONSHIP			RELATIONSHIP
COLORECTAL CANCER	_____		**HIGH BLOOD PRESSURE**	_____	
COLON POLYPS	_____		**ANOTHER TYPE OF CANCER**	_____	
DIABETES	_____		**OTHER MEDICAL PROBLEMS**	_____	
HEART PROBLEMS	_____				

ADDITIONAL COMMENTS

_____

_____

_____ _____

Signature of Patient or Legal Guardian Date