

Date of Visit _____ Name _____

Blood Pressure _____
 Weight _____
For Office Use Only

_____ Date of Birth _____ Occupation _____

_____ Referring Physician _____ Primary Care Physician if different _____ Preferred Pharmacy & Location _____

Prescription Medication	Dose & Frequency	Over the Counter Medication	Dose & Frequency

Please list any known allergies to medication

Medication	Type of Reaction

Do you drink alcohol? Yes/No
 If yes, how often? _____

Reason for Visit: _____

Have you ever smoked? Yes/No If **yes**, are you currently smoking? Yes/No If **no**, how long ago _____

If you are currently smoking, how often per day? _____

If applicable, please list the family member (mother, brother, son, etc) who has had stomach cancer, colon polyps, or colon cancer.
 _____ stomach cancer, colon polyps, colon cancer. Circle all that apply.

Please list the age your family member(s) was diagnosed. _____

Please list any surgery you have ever had: _____

Please check all the medical conditions below that you are now receiving treatment for or have in the past.

GI	Current	Past	General	Current	Past	Musculoskeletal	Current	Past
GERD/Reflux/Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	Under Active Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>
Irritable Bowel	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	Current	Past
Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	Current	Past	Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Heart	Current	Past	Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Liver	Current	Past
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Esophageal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Fatty Liver	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hemochromatosis	<input type="checkbox"/>	<input type="checkbox"/>
Stents	<input type="checkbox"/>	<input type="checkbox"/>	Testicular Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker w/defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Ascities	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker w/o defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	Varcies	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	Current	Past	Psych	Current	Past	Other, please specify	Current	Past
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
			Bipolar	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>