**Current Medications** *(include any over the counter medicines, vitamins, supplements, & diet pills)*

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose/Strength</th>
<th>When taken (daily, as needed, etc.)</th>
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**DRUG ALLERGIES:**

______________________________________________________________

Pharmacy Preference: _________________________ Location: _________________ Phone #: __________________

**Past Surgeries / Date**

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Have you had a COLONOSCOPY previously? □ NO □ Yes (When? Where?) _________________________

Have you had an EGD (upper scope) previously? □ NO □ Yes (When? Where?) _________________________

**CURRENT WEIGHT:** ____________ **HEIGHT:** ____________ *(Staff use, BMI: ____________)*

**FAMILY HISTORY—Mark box for any problems that run in your family and tell us what relative (circle M=mother, F=father, B=brother, S=sister)*

- Colon polyps (M  F  B  S)
- Blood disorders (M  F  B  S)
- Other diseases (M  F  B  S)
- Cancer (M  F  B  S)
- Gastric polyps (M  F  B  S)
- Pancreatitis (M  F  B  S)
- Type: ______________
- Liver disease (M  F  B  S)
- Ulcers (M  F  B  S)
- Type: ______________

**SOCIAL HISTORY**

Have you ever smoked? □ Yes □ No  Do you currently smoke? □ Yes □ No
If yes, how many packs per day? __________

Have you ever used alcohol? □ Yes □ No  Do you currently use alcohol? □ Yes □ No
If yes, how much? □ Daily □ Weekly □ Monthly □ Other: __________

Have you ever used recreational drugs? □ Yes □ No  Do you currently use? □ Yes □ No

**COMMENTS**
<table>
<thead>
<tr>
<th>NO/YES</th>
<th>Review of Systems—Please mark NO or YES for each item if you have the problem.</th>
</tr>
</thead>
</table>
| **Constitutional** | □ □ Chills  
□ □ Fever  
□ □ Malaise/Fatigue  
□ □ Weight Loss  
□ □ Head/Eyes/ENT  
□ □ Double vision  
□ □ Ear infections  
□ □ Eye pain  
□ □ Nasal congestion  
□ □ Sinus infection  
□ □ Asthma  
If yes, last attack ____________  
□ □ Ever hospitalized for attack? When? ____________  
□ □ Bronchitis  
□ □ Emphysema/COPD  
□ □ Home use of oxygen  
□ □ Pneumonia  
□ □ Prior airway difficulties  
□ □ Productive cough  
□ □ Recent URI  
□ □ Sleep Apnea  
□ □ If yes, CPAP?  
□ □ Tuberculosis  
□ □ Chest pain If yes, Frequency: ____________  
Duration: ____________  
Last occurrence: ____________  
Caused by: ____________  
Occurs at rest? ____________  
What makes it go away? ____________  
□ □ Swelling in hands/feet  
□ □ Palpitations/irregular beat  
□ □ Heart attack  
If yes, when? ____________  
□ □ Heart valve disease  
□ □ High blood pressure  
□ □ Congestive heart failure  
If yes, last episode ____________  
EF % ____________  
□ □ Cardiac stents  
□ □ Palpitations/irregular beat  
□ □ Swelling in hands/feet  
□ □ Bronchitis  
What makes it go away? ____________  
□ □ Cardiovascular  
□ □ Sinus infection  
□ □ Prior airway difficulties  
□ □ Wheezing  
□ □ Ever hospitalized for attack? When? ____________  
□ □ Pulmonary edema  
□ □ Hypertension  
□ □ Hypothyroidism  
□ □ Hyperthyroidism  
□ □ Anemia  
□ □ Polycythemia  
□ □ Thrombocytosis  
□ □ Leukocytosis  
□ □ Leukopenia  
□ □ Thrombocytopenia  
□ □ Nephrotic syndrome  
□ □ Nephritic syndrome  
□ □ Nephrosis  
□ □ Nephritic nephrosis  
□ □ Pyelonephritis  
□ □ Pyelitis  
□ □ Ureteritis  
□ □ Urethritis  
□ □ Genitourinary  
□ □ Burning with urination  
□ □ Blood in urine  
□ □ Urinary frequency  
□ □ Urinary incontinence  
□ □ Urinary retention  
□ □ Dialysis  
□ □ Renal insufficiency  
□ □ Renal failure  
□ □ Polyuria  
□ □ Polydipsia  
□ □ Polyuria/polydipsia  
□ □ Oliguria  
□ □ Hypertension  
□ □ Hypotension  
□ □ Hypertensive crises  
□ □ Hypotensive crises  
□ □ Hypertensive urgency  
□ □ Hypotensive urgency  
□ □ Hypertensive emergency  
□ □ Hypotensive emergency  
□ □ Hypertensive crisis  
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□ □ ...