Preferred Pharmacy:_____**City:**_____

Patient Name: _____ Sex: M / F Age: _____ DOB: ____/____/_____

PAST MEDICAL HISTORY *(Check all that apply)* **DATE:**

Heart attack/ angina _____ _____
Abnormal heart rhythm _____ _____
Valvular heart disease _____ _____
Pacemaker / Defibrillator _____ _____
Lung Disease / Asthma _____ _____
High Blood Pressure _____ _____
Stroke/ TIA _____ _____
High cholesterol/ Lipids _____ _____
Diabetes: Type I or II _____ _____
Thyroid Disease _____ _____
Cancer /Tumor: Specify _____ _____
Anemia _____ _____
Glaucoma _____ _____
Food Allergies _____ _____
Celiac Disease: _____ _____
Gallstones: _____ _____
Liver Disease/ Hepatitis: _____ _____

OTHERS:_____
_____
_____
_____
_____

FAMILY HISTORY:
Please specify family member:
F / M / PGF / PGM / MGF / MGM / sibling

Colon cancer: _____
Crohns disease: _____
Ulcerative Colitis: _____
Irritable bowel syndrome: _____
Esophageal Cancer: _____
Stomach Cancer: _____
Pancreases Disease/Cancer: _____
Other Cancer: _____
Gallstones: _____
Celiac Disease: _____
Liver Disease: _____
Other: _____

DRUG ALLERGIES and REACTION: Including:
_____IV Contrast Dye _____Latex
_____Iodine _____Shellfish
_____
_____

Travel outside the US in the last 3 years: _____
When & where: _____

GASTROINTESTINAL HISTORY:
Have you ever had the following procedures?

Colonoscopy: _____
Date: _____Location:_____
Flexible Sigmoidoscopy: _____
Date: _____Location:_____
Upper Endoscopy (EGD): _____
Date: _____Location:_____

*Do **you** have any history of the following?*
Colon polyps / Cancer: _____
Stomach /Duodenal Ulcer: _____
Irritable bowel syndrome: _____
Pancreatitis: _____
Inflammatory Bowel Disease: _____

OPERATIONS /PROCEDURES:
Please list the year of the operation:
_____
_____
_____
_____
_____

SOCIAL HISTORY:
Occupation: _____
Marital Status: _____

Substance Use:

Tobacco: Smoking or Chew
Use: Past or Present
Length of use: _____
Packs per day: _____

Alcohol Use: _____Drinks per week_____
Illegal Drug use: _____Type: _____Last Used: _____

Do you drink caffeine (coffee, tea, soda)? _____
If yes, how much & how often: _____
Have you *ever* had a blood transfusion?
NO / YES Year: _____
Do you have tattoos: _____

Women only: what is the date of your last menstrual cycle: _____/_____/_____