

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Sex:  M  F Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Have you had any falls recently?  Y  N Are you a current/previous smoker?  Y  N

Rate your pain from 0 (no pain) to 10 (the worst pain you've ever had) \_\_\_\_\_

Why are you seeing the doctor today? \_\_\_\_\_

List your symptoms \_\_\_\_\_

**(Women Only)** When was your last menstrual period? \_\_\_\_\_

What are your current medications? **Please list names of medication and dosages**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you **allergic** to any medication? \_\_\_\_\_

**Please list any and ALL surgeries or procedures you have ever had** (list the year if known)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had problems with anesthesia in the past?  Yes  No  
If yes, what reaction did you have? \_\_\_\_\_

**Do you have any of the following?**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Kidney Disease                   | <input type="checkbox"/> Hard of Hearing      |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Colon Problems   | <input type="checkbox"/> Cancer-- <i>What kind?</i> _____ |   |
| <input type="checkbox"/> Hemorrhoids         | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Stroke or TIA                    | <input type="checkbox"/> Heart Disease        |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker        | <input type="checkbox"/> Mitral Valve Prolapse            | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Lung Disease     | <input type="checkbox"/> Asthma                           | <input type="checkbox"/> Sleep Apnea          |

List any other medical history not listed above \_\_\_\_\_

**DO YOU TAKE:**

Aspirin  Y  N  
Coumadin  Y  N  
Glucophage/Metformin  Y  N  
Plavix  Y  N

**ARE YOU ALLERGIC TO:**

LATEX?  Y  N  
DYES?  Y  N  
TAPE?  Y  N

Have you had a CHEST X RAY in the past year?  Y  N If yes, when and where? \_\_\_\_\_

Have you had an EKG in the past year?  Y  N If yes, when and where? \_\_\_\_\_

Have you ever had a COLONOSCOPY?  Y  N If yes, when and where? \_\_\_\_\_

**SOCIAL HISTORY**

Alcoholic beverages?  Y  N How much?  Daily  Occasionally  Rarely

Please circle:  Wine  Beer  Liquor Is there a history of alcohol abuse?  Y  N

Do you use Illicit Drugs?  Y  N

What is your Marital Status?  Married  Single  Divorced  Widow(er)

Do you have a living will?  Y  N

Is your Mother living?  Y  N What is/was her health history? \_\_\_\_\_

Is your Father living?  Y  N What is/was his health history? \_\_\_\_\_

Please list any **Family History** of chronic illness or disease

\_\_\_\_\_  
\_\_\_\_\_

Is there a **Family History** of colon cancer?  Y  N If so, who? \_\_\_\_\_

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**Please return to the receptionist when you are done. Thank you.**

**Signature** \_\_\_\_\_

**Date:** \_\_\_\_\_