# HISTORY AND PHYSICAL

Date: _____

Patient Name: _____ Age: _____

Chief Complaint/Reason for visit: _____

Have you experience any of the following: (Please circle YES or NO)

| | |
|---|---|
| Weight loss ( _____ lbs in _____months) | YES or NO |
| Appetite Changes | YES or NO |
| Rectal Bleeding | YES or NO |
| Black Stools | YES or NO |
| Difficulty Swallowing | YES or NO |
| Heart Burn | YES or NO |
| Abdominal Pain | YES or NO |
| Chest Pain | YES or NO |
| Constipation | YES or NO |
| Diarrhea | YES or NO |
| Nausea | YES or NO |
| Vomiting | YES or NO |

Medications: _____

_____

_____

_____

Allergies and Reaction: _____

Please list previous surgeries:

| Surgery | Date: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Previous EGD: _____
Date Location

Previous Colonoscopy: _____
Date Location

Screening for women: Have you had a recent mammogram? _____
Pap smear? _____

Screening for men: Have you had a recent PSA? (Prostate test) _____

Please answer the following about YOUR Past Medical History:

Have you had the following: Please circle YES or NO. If YES then specify year.

| | | | YEAR |
|---|---|---|---|
| AV Shunt/ Dialysis | YES | NO | _____ |
| Blood Transfusion | YES | NO | _____ |
| Colon Cancer/Polyps | YES | NO | _____ |
| Diabetes | YES | NO | _____ |
| Emphysema/Bronchitis/Asthma | YES | NO | _____ |
| Gallstones | YES | NO | _____ |
| Heart Attack | YES | NO | _____ |
| Heart Disease | YES | NO | _____ |
| Heart Murmur/Mitral Valve Prolapse | YES | NO | _____ |
| Hepatitis | YES | NO | _____ |
| High Blood Pressure | YES | NO | _____ |
| Hip/Joint Replacement | YES | NO | _____ |
| Cancer | YES | NO | _____ |
| Liver Disease | YES | NO | _____ |
| Prosthesis | YES | NO | _____ |
| Stroke | YES | NO | _____ |
| Ulcers | YES | NO | _____ |
| High Cholesterol/Lipids | YES | NO | _____ |

Other _____

Do you have FAMILY HISTORY of the following:

| | | |
|---|---|---|
| Colon Cancer/Polyps | YES | NO |
| Breast Cancer | YES | NO |
| Pelvic Cancer | YES | NO |
| Any other types of cancer? | YES | NO |

Specify: _____

| | | |
|---|---|---|
| Gallbladder disease | YES | NO |
| Liver Disease | YES | NO |
| Peptic Ulcer Disease | YES | NO |

SOCIAL HISTORY:

Do you use tobacco? _____ How Much? _____ Length of time? _____
Do you use alcohol? _____ How Much? _____ Length of time? _____
Marital Status: _____
Number of Pregnancies _____ Abortions _____ Miscarriages _____
Children _____
Occupation: _____