Patient Intake

Date: _____

Name: _____ DOB: _____ Age: _____

Reason for today's appointment: _____

_____

List all current medications taken (include dosage, vitamins, over-the-counter, and food supplements): _____

_____

_____

Allergies and Sensitivities: _____

_____

List surgeries and hospitalizations you have had (include year, surgeon, and hospital): _____

_____

_____

Have you ever had a colonoscopy? Yes or No If yes, please fill out the following information.

What doctor: _____

When: _____ Where: _____

Medical History (Please circle all that apply):

Migraines	Hepatitis	Abnormal bleeding	High cholesterol	High blood pressure
Head injury	Tuberculosis	Blood clots	Sleep apnea	Stroke
Depression	Polio	Blood transfusion	Asthma	Alcoholism
Mental illness	Diabetes	Anemia	COPD	Migraines
Seizures	Kidney disease	Kidney stones	Heart murmur	Drug addiction

Abnormal Pap smear Hearing trouble Hyperthyroidism Hypothyroidism

STDs/HIVs (Please Specify):_____ Cancer (Please specify): _____

Other: _____

Family History

Who in your family has/had (indicate age if cause of death):

Colon cancer: _____ Colon polyps: _____

Familial polyposis: _____

Inflammatory bowel disease (Crohn's disease, Ulcerative colitis): _____

Breast, ovarian, or uterine cancer (circle which): _____

Genetic Disorder: _____ Problems with anesthesia: _____

Problems bleeding or clotting: _____ Heart disease: _____

Social History

Who lives in your household: _____
Where do/did you work: _____
Weight: _____ Height: _____ Do/did you smoke: _____ How much: _____ Year quit: _____
Do/did you drink alcohol: _____ How much: _____ Year quit: _____
Previous/current problem with alcohol: _____
Do/did you use: caffeine marijuana cocaine chewing tobacco tobacco diet pills
Describe your diet: _____
_____

Do you have problems with:

Stools: blood thinning/ribbon like mucous loose/watery hard seepage
Bowel Movements: pain urgency straining protrusion/swelling
Urinary: incontinence urgency retention
Other: bloating/cramping abdominal pain fevers/chills heartburn vomiting stool in urine from vagina incontinence of stool/gas

Describe stomach, intestinal, colon, digestion, or bowel movement problems: _____
_____

Describe skin problems: _____
_____

Describe lung/breathing problems: _____
_____

Describe urinary trouble: _____
_____

Describe sexual concerns: _____
_____

Describe bone, muscle or joint problems: _____
_____

Describe hormone problems: _____
_____

Describe any problem with your thinking, concentration or neurologic function: _____
_____

Any other concerns or health problems: _____

Patient signature: _____ Date: _____

Date of birth _____