

Circle any of the following medications you are taking, even on an occasional basis:

Coumadin, Heparin, Lovenox, other anticoagulant or blood thinner

Advil, Motrin, Ibuprofen, other medicine for pain

Aspirin, Alka-Seltzer, Aspirin containing products

Alcohol, Drug and Tobacco History:

Cigarette/Cigar/Pipe: Never _____ Former _____ Year Quit? _____

Current : Amount per week _____ Per day _____

Smokeless (chew): Amount per week _____ Per day _____

Do you drink Alcohol?: No _____ Yes _____

Describe your use of alcohol: _____

Amount per week: Beer _____ Wine _____ Liquor: _____

Recreational and intravenous drugs: Never _____ Past _____ Current: _____

Have you ever attended or felt you should attend a drug or alcohol rehabilitation program?

No Yes If yes, explain: _____

Do you have any Tattoos? No _____ Yes _____ Year? _____

Have you ever had a blood transfusion? No _____ Yes _____ Year? _____

Occupation: _____

Family History: Has any of your Blood relatives had any of the following? Explain the relationship (father, sister, uncle, etc.)

Colon polyps No _____ Yes _____ Who and what age? _____

Colon Cancer No _____ Yes _____ Who and What age? _____

Other Cancers: (Circle) Esophagus, Stomach, Pancreas, Liver, Breast, Ovarian, Other

Who and What age?: _____

Stomach Ulcers No Yes

Liver Disease No Yes

Heart Disease/Stroke/ High Blood Pressure No Yes

Diabetes No Yes

Inflammatory Bowel Disease/ Ulcerative Colitis/ Crohn's No Yes

Other? Explain _____

Please Turn Page over to back

Please Circle any symptoms you have had.

REVIEW OF SYSTEMS

Anorexia
Fatigue
Fever
Weight Gain > 10 lbs.

Weight Loss > 10 lbs.
Appetite Loss

MUSCULOSKELETAL

Joint Stiffness
Back Pain

NEUROLOGICAL

Headaches
Syncope
Seizures
Weakness
Dizziness
Incontinence Stool
Stroke

PSYCHIATRIC

Anxiety
Depression
Hallucinations
Suicidal Ideation
Suicidal Planning
Insomnia
Inability to Concentrate
Panic Attacks
Mood Changes

ENDOCRINE

Sexual Dysfunction

HEMATOLOGY

Anemia
Enlarged Lymph Nodes
Petechiae
Abnormal Bleeding
Blood Clots

Nose Bleed

MALE GENITOURINARY

Testicular Mass
Testicular Pain

HEENT

Change in Vision
Headache
Eye Redness
Decreased Hearing
Bleeding Gums
Hoarseness
Ringing in the Ears
Nose Bleed

NECK

Neck pain
Neck Stiffness

RESPIRATORY

Cough
Dyspnea
Hemoptysis
Sputum Production
Wheezing

BREAST

Breast Pain
Gynecomastia

CARDIOVASCULAR

Chest Pain
Hypertension
Palpitations
Shortness of Breath
Difficulty Breathing Lying
Down

Leg pain and/or Swelling
Swelling of Extremities
Fainting

GASTROINTESTINAL

Abdominal Mass
Abdominal Pain
Change in Bowel Habits
Constipation
Diarrhea
Dysphagia
Food Intolerance
Bloody Stool
Gas
Heartburn
Indigestion
Hematemesis
Jaundice
Melena
Nausea
Rectal Bleeding
Vomiting
Vomiting Blood
Black, Tarry Stool

SKIN

Pruitus
Rash
Bruising

Any information you would like to add? Explain: _____

Women: Last menstrual period _____

Last pap smear _____

Last Mammogram _____

Men:

Last prostate check _____

Testicular exam _____

This form was completed by (circle): Self

Other (name)

(rev. 10/06)