GASTROENTEROLOGY, LTD.
COLON CANCER PREVENTION AND ENDOSCOPY CENTER OF VIRGINIA BEACH

Patient History Form

Name: _____ Date: _____

Date of Birth: _____ Ht: _____ Wt: _____

Referring Physician: _____

Reason for visit: _____

PLEASE LIST ALL ALLERGIES AND REACTION including medications, food, and environmental:

NO ALLERGIES: ☐

Allergy	Reaction	Allergy	Reaction
(1)		(3)	
(2)		(4)	

Review of Systems: Please check (✓) any conditions that currently represent a SIGNIFICANT problem.

GASTROINTESTINAL			
	Yes (✓)		Yes (✓)
Abdominal pain	☐	Diarrhea	☐
Nausea and vomiting	☐	Constipation	☐
Heartburn or indigestion	☐	Rectal pain	☐
Loss of appetite	☐	Rectal bleeding	☐
Trouble swallowing	☐	Blood in stool	☐
Hemorrhoids	☐	Tarry stools	☐

General	Yes (✓)	Cardiovascular	Yes (✓)	Musculoskeletal	Yes (✓)
Fever or chills	☐	Chest pain	☐	Back pain	☐
Night sweats	☐	Heart palpitations	☐	Leg pain	☐
Recent weight changes	☐	Irregular heart beat	☐	Muscle weakness	☐
Ears, Nose, Mouth		Feet or ankle swelling	☐	**Neurologic**	
Nose bleeds	☐	**Genitourinary**		Numbness	☐
Sinus problems	☐	Painful urination	☐	Headaches	☐
Earache	☐	Urgency	☐	Dizziness	☐
Dentures	☐	Slow or small stream	☐	**Skin**	
Hearing loss	☐	Leaking of urine	☐	Rash, dryness, itching	☐
Pulmonary		Menstrual problems	☐	Jaundice	☐
Chronic cough, wheezing	☐	**Endocrine**		Easy bruising	☐
Shortness of breath	☐	Heat or cold intolerance	☐	Pigment changes	☐
		Hot flashes	☐	**Psychiatric**	
		Excessive thirst	☐	Depression	☐
		Flushing	☐	Anxiety	☐
				Other	☐

Please list your medications, the dosage and how often you take each. Include over-the-counter medications as well as herbal products.

NO MEDICATIONS: ☐

	Name of Medication	Dose	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Past Medical History: Please check (✓) any conditions that you have been diagnosed with and/or are currently being treated for:

Pulmonary History	(✓)	General Medical History	(✓)	GI History	(✓)
Asthma		Anemia		Abdominal pain	
Bronchitis		Anesthesia reaction		Change in bowel habits	
Chronic cough		Diabetes		Ulcerative colitis	
COPD		Exposure to communicable disease		Diarrhea	
Difficult to intubate				Diverticulosis	
Emphysema		Glaucoma		Diverticulitis	
Sleep apnea		Recent treatment for infection		Hiatal hernia	
Shortness of breath		Metabolic disorder		Jaundice	
TB		MRSA		Prostate disease	
Cardiac History		Blood transfusion? Date		Colon polyps	
AICD				Celiac disease	
Arrhythmia		Thyroid disease		Constipation	
Chest pain		Transplant		Crohn's disease	
Heart disease		**GU History**		Frequent UTI	
Heart failure		Dialysis		GI ulcers	
Hypertension		Frequent UTI		Hemorrhoids	
Heart attack		Kidney disease		Hepatitis	
Mitral valve prolapse		Kidney stones		Rectal bleeding	
Pacemaker				Reflux/Heartburn	
Heart murmur				Varices	
Blood Disorder History				Pancreatic disease	
DIC/Blood clotting disorder				Cirrhosis of the liver	
Excessive bleeding				Gallbladder disease	
Sickle cell				Gallstones	
Cancer History				**Neuromuscular History**	
Colon cancer				Arthritis	
Other GI cancer: Specify:				Back pain	
				Headaches	
Ovarian cancer				Hip fracture	
Endometrial cancer				Joint replacement	
Prostate cancer				Leg pain	
Pancreatic cancer				Muscle weakness	
				Seizures	
				Stroke	

Other Medical History: _____

_____

Date of Last Hepatitis A Vaccine: _____ **Hepatitis B Vaccine** _____

Family History: Please check (✓) any family history and indicate which relative.

	✓	Relative		✓	Relative
Colon polyps			Celiac disease		
Colon cancer			Gallbladder disease/gallstones		
Endometrial cancer			Liver disease		
Ovarian cancer			Crohn's disease		
Pancreatic cancer			Ulcerative colitis		

(ONE MORE PAGE…PLEASE CONTINUE!)

Social History:
Marital Status - Please circle: Single Divorced Married Widow/Widower Other

Occupation: _____

Current tobacco products: Yes ☐ No ☐ Passive ☐ If yes, packs per day ( ) Years ( )
Cigarettes / Pipe / Cigars / Chew (please circle type)

Past tobacco products: Yes ☐ No ☐ If yes, when did you quit? _____

Do you drink alcohol? Yes ☐ No ☐ Beer/Liquor/Wine Drinks per week _____

Did you ever drink heavily? Yes ☐ No ☐ How long did you drink heavily? _____

Do you drink coffee/tea? Yes ☐ No ☐ How much? _____

Do you drink soda? Yes ☐ No ☐ How much? _____

Use of street drugs? Yes ☐ No ☐

Body piercings? Yes ☐ No ☐ Locations: _____

Tattoos? Yes ☐ No ☐

Family history of
anesthesia reaction? Yes ☐ No ☐ What relationship? _____

Any beliefs that would alter
health care decisions? Yes ☐ No ☐

Use of assistive devices? Yes ☐ No ☐
(Oxygen, apnea monitor or CPAP, wheelchair)

List any special considerations: (for example, Interpreter required, etc.) _____

Please list any hospitalizations and surgeries with an approximate date of hospitalization

Date	Reason for hospitalization or surgery

Patient signature _____ Date _____