TO BE COMPLETED BY PATIENT

Date: ______________________ Phone: ______________________

Name: ______________________ Date of Birth: ______________________

Reason for Visit: ______________________

PLEASE CHECK IF YOU OR A FAMILY MEMBER HAS HAD ANY OF THE FOLLOWING ILLNESSES:

(If a family member, please indicate father, mother, sister, etc., under "who")

	Who		Who
☐ Ulcerative Colitis	______	☐ Celiac Sprue	______
☐ Ulcer Disease	______	☐ Liver Disease	______
☐ Colonic Polyps	______	☐ Crohn's Disease	______
☐ Colonic Carcinoma	______		

PLEASE CHECK ANY OF THE SYMPTOMS YOU HAVE EXPERIENCED DURING THE LAST YEAR:

☐ Heartburn / Reflux	☐ Abdominal Pain	☐ Headache
☐ Bloating	☐ Diarrhea	☐ Weakness
☐ Fainting	☐ Constipation	☐ Back Pain
☐ Hoarseness	☐ Blood in Stool	☐ Lightheadedness
☐ Cough	☐ Difficulty Swallowing	☐ Weight Loss
☐ Chest Pain / Tightness	☐ Change in Bowel Habits	☐ Weight Gain
	☐ Nausea / Vomiting	

☐ Do you smoke? ☐ Yes ☐ No If yes, how much: ______________________

☐ Do you use alcohol? ☐ Yes ☐ No If yes, how much: ______________________

☐ Do you use drugs? ☐ Yes ☐ No

☐ Do you drink coffee or tea? ☐ Yes ☐ No If yes, how much: ______________________

☐ What is your occupation? ______________________

____

(Patient Signature)

Name: ______________________ Date of Birth: ______________ Date: ______________

Pharmacy name: ______________________ Pharmacy Address: ______________________

PART II

Please list all current medications (prescription and non-prescription):

NAME OF MEDICATION	DOSE	HOW OFTEN YOU TAKE	PURPOSE

Allergies: Drug: ______________________

PAST HISTORY

Medical illnesses: ______________________

Hospitalizations:
Medical: ______________________

Surgical: ______________________

FAMILY HISTORY

Father: ______________________ Mother: ______________________

Brothers: ______________________ Sisters: ______________________