MEDICAL INFORMATION

Reason for visit: ____.

Do you have or have you had any of the following:

Diabetes ______
Heart Attack ______
High Blood Pressure ______
Pacemaker ____
Heart Murmur _____
Kidney Disease ____
Stroke____
Heart Disease ____
Sleep Apnea ______
Defibrillator ____
Heart Valve Disease ____
Seizure Disorder _____
Mitral Valve Prolapse ____
High Cholesterol _____
Thyroid Disease _____
Joint Replacement _____
Hepatitis ______
Anemia ______
Asthma ______
COPD ______
Liver Disease ___

Other medical/psychiatric conditions: ____.

Past Surgical History (list **ALL** surgeries and the dates):
____.
____.
____.

Are you under the care of any other physicians/specialists? Yes ___ No ___

If yes, list name and specialty: ____
____.

Do you require information to be released to above physicians? Yes ____ No ____

Is there any family history of colon polyps, colon cancer or any other cancers? Yes ___ No ___

If yes, what type and who? ____.

Do you smoke? Yes___ No___ If yes, how long? _______

Do you drink alcohol? No ___ Occasionally ___ Regularly ___

Do you have a history of previous drug abuse? Yes ___ No___

Please list all prescription medications taken including over the counter products and the dosing instructions:

__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________

Do you have any allergies to any medications? Yes____ No _____

Name of drugs: ____

Type of Reaction: ____

Gastro-Intestinal: Have you ever experienced any of the following?

Vomiting Blood ____
Rectal Bleeding ___
Diarrhea ___
Constipation ___
Change in Bowel Habits ___
Difficulty Swallowing ___
Black Stools ___
Weight Loss ___

Have you had a previous colonoscopy/endoscopy? Yes ___ No ___

When _________________ Where ____