NAME: | **DOB:**

BRIEFLY TELL US WHY YOU ARE HERE:

PRIMARY CARE PHYSICIAN:______________________________ **CARDIOLOGIST:**____________________________________

OB/GYN:____ **GASTROENTEROLOGIST:**___________________________________

REFERRING PHYSICIAN:_____________________________________

PHARMACY:

LOCAL: NAME: ____ PHONE ___________________________

CROSSROADS: ____ ZIP: ___________________________

MAIL IN: NAME: ____ PHONE: ___________________________

CROSSROADS: ____ ZIP: ___________________________

PAST OR PRESENT MEDICAL CONDITIONS: ☐ **NONE**

GASTROINTESTINAL

- ☐ HEPATITIS A
- ☐ HEPATITIS B
- ☐ HEPATITIS C
- ☐ JAUNDICE
- ☐ CIRRHOSIS
- ☐ LIVER DISEASE
- ☐ PEPTIC ULCER DISEASE
- ☐ CROHN'S DISEASE
- ☐ LACTOSE INTOLERANCE
- ☐ ULCERATIVE COLITIS
- ☐ PANCREATITIS
- ☐ GALLSTONES
- ☐ COLITIS
- ☐ COLON POLYPS
- ☐ COLON CANCER
- ☐ IBS (IRRITABLE BOWEL SYND)
- ☐ DIVERTICULITIS
- ☐ BARRETT'S
- ☐ GERD
- ☐ ESPOHAGEAL DISORDER

ENDOCRINE

- ☐ OSTEOPOROSIS
- ☐ OSTEOPENIA
- ☐ DIABETES
- ☐ THYROID PROBLEMS

CANCER

- ☐ SPECIFY TYPE______________________

CARDIOVASCULAR

- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HIGH TRIGLYCERIDES
- ☐ HISTORY OF HEART ATTACK
- ☐ HISTORY OF ANGINA
- ☐ CONGESTIVE HEART FAILURE
- ☐ ATRIAL FIBRILLATION
- ☐ OTHER HEART RHYTHM DISTURB.
- ☐ CARDIAC STENTS
- ☐ IRREGULAR HEARTBEAT
- ☐ MITRAL VALVE PROLAPSE
- ☐ ARTIFICIAL VALVES
- ☐ HEART MURMUR
- ☐ RHEUMATIC FEVER
- ☐ PACEMAKER
- ☐ DEFIBRILLATOR

RESPIRATORY/LUNG

- ☐ CHRONIC BRONCHITIS
- ☐ EMPHYSEMA
- ☐ ASTHMA
- ☐ HISTORY OF LEG CLOTS
- ☐ SLEEP APNEA (WITH STUDY)
- ☐ OXYGEN USE

GENITOURINARY

- ☐ KIDNEY STONE
- ☐ KIDNEY FAILURE
- ☐ KIDNEY DISEASE
- ☐ DIALYSIS
- ☐ PROSTATE CANCER
- ☐ PROSTATE ENLARGEMENT

PSYCHOLOGY

- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ PANIC ATTACKS
- ☐ OTHER ______________________

HEMATOLOGY

- ☐ ANEMIA
- ☐ BLOOD DISORDER
- ☐ PHLEBITIS OR BLOOD CLOTS
- ☐ BLEEDING TENDENCY

NEUROLOGY

- ☐ MIGRAINE
- ☐ STROKE
- ☐ T.I.A. (MINI STROKE)
- ☐ SEIZURE

RHEUMATOLOGY

- ☐ ARTHRITIS
- ☐ FIBROMYALGIA
- ☐ AUTOIMMUNE DISEASE
- ☐ (LUPUS, R.A.)

EYE

- ☐ GLAUCOMA

CATARACTS

- ☐ CONJUNCTIVITIS

SKIN

- ☐ PSORIASIS

OTHER SKIN DISORDER____________________

HIV ☐ NO ☐ YES ☐ NOT TESTED

AIDS ☐ NO ☐ YES

HERPES ☐ NO ☐ YES

ALLERGIES: ☐ **NO KNOWN ALLERGIES**

LATEX ALLERGY? ☐ - **NO** ☐ - **YES**

MEDICATION ALLERGIES: ☐ - **NO** ☐ - **YES, PLEASE LIST**

FAMILY MEDICAL HISTORY:

NAME:____**DOB:**______________ ☐ **NONE**

PLEASE INDICATE FAMILY MEMBERS (PARENTS, SIBLINGS AND CHILDREN)THAT HAVE HAD:

☐ **COLON AND/OR RECTAL CANCER** ☐ **POLYPS** ☐ **ULCERATIVE COLITIS** ☐ **CROHNS DISEASE**

LIST EACH FAMILY MEMBER, HOW THEY ARE RELATED AND AGE DIAGNOSED: ______________________________________

☐ **DIABETES** ☐ **HEART DISEASE** ☐ **HYPERTENSION** ☐ **STROKE** ☐ **SEIZURES** ☐ **OTHER CANCERS**

LIST EACH FAMILY MEMBER, HOW THEY ARE RELATED AND AGE DIAGNOSED: ______________________________________

SOCIAL HISTORY

PROFESSION:____________________________**MARITAL STATUS:** ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED

TOBACCO

DO YOU SMOKE? ☐ - YES ☐ - NO

IF YES, HOW MANY PACKS PER DAY? _____

FOR HOW MANY YEARS? _____________

IF QUIT, WHEN? _______________

ILLICIT DRUG USE ☐ - YES ☐ - NO

DRUG OF CHOICE _______________

DATE OF LAST USE _______________

ALCOHOL USE

DO YOU DRINK? ☐ - YES ☐ - NO

IF YES, WHAT TYPE?

BEER LIQUOR WINE

HOW OFTEN? _______________

HOW MANY GLASSES PER OCCASION? ____

BLOOD TRANSFUSION

☐ - NO ☐ - YES, WHEN?

____

CAFFEINE USE

DO YOU DRINK? ☐ - YES ☐ - NO

IF YES WHAT TYPE?

TEA COFFEE SODA

HOW MANY CUPS PER DAY? CIRCLE ONE

1 2 3 4 5 >5

TATTOOS

☐ - YES # _______ ☐ - NO

DO YOU TAKE A BLOOD THINNER? ☐- **NO** ☐- **YES**

(CIRCLE) **COUMADIN / WARFARIN / ASPIRIN / OTHER**__________________________

CURRENT MEDICATIONS: ☐**NONE** **OR** ☐**SEE ATTACHED LIST (PLEASE INCLUDE NAME, DOSE, FREQUENCY)**

PLEASE ASK RECEPTIONIST FOR ADDITIONAL PAGE IF NEEDED

NAME	DOSE	FREQUENCY

PROCEDURES/SURGICAL HISTORY **NAME:** **DOB:**

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

		NO		YES	DATE:	FINDINGS;
COLONOSCOPY		NO		YES	DATE:	FINDINGS;
ERCP		NO		YES	DATE:	FINDINGS;
UPPER ENDOSCOPY-EGD		NO		YES	DATE:	FINDINGS;
BARIUM ENEMA		NO		YES	DATE:	FINDINGS;
BONE DENSITY ☐ NO ☐ YES DATE:						
OTHER SURGERIES:					DATE:	FINDINGS;

REVIEW OF SYSTEMS:

IN THE PAST 2 – 3 MONTHS, HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS?

GENERAL

- ☐ RECENT WEIGHT CHANGES
- ☐ EXCESSIVE FATIGUE
- ☐ FEVER
- ☐ CHILLS

ENMT

- ☐ RECENT CHANGE IN VISION
- ☐ EYE REDNESS
- ☐ RINGING IN EARS/TINNITUS
- ☐ NOSE BLEEDS
- ☐ SINUSITIS
- ☐ SORE THROAT
- ☐ HOARSENESS/VOICE CHANGES
- ☐ RECURRENT MOUTH ULCERS
- ☐ DENTAL PROBLEMS
- ☐ BLEEDING GUMS
- ☐ CATARACTS/GLAUCOMA
- ☐ DIFFICULTY SWALLOWING

CARDIOVASCULAR

- ☐ CHEST PAIN/PRESSURE
- ☐ PALPITATIONS
- ☐ SWELLING IN FEET/ANKLES
- ☐ CRAMPS WITH EXERCISE
- ☐ IRREGULAR HEARTBEAT
- ☐ ABNORMAL STRESS TEST
- ☐ HEART MURMUR
- ☐ ABNORMAL HEART VALVE
- ☐ HIGH CHOLESTEROL

RESPIRATORY

- ☐ SHORTNESS OF BREATH
- ☐ PERSISTENT COUGH
- ☐ COUGHING BLOOD OR SPUTUM
- ☐ WHEEZING

GENITOURINARY

- ☐ BLOOD IN URINE
- ☐ BURNING WITH URINATION
- ☐ DIFFICULTY WITH URINATION
- ☐ UP AT NIGHT TO URINATE
- ☐ FREQUENT URINATION
- ☐ PAINFUL URINATION
- ☐ URINARY INCONTINENCE
- ☐ FREQUENT BLADDER INFECTIONS

FEMALE

- ☐ PREGNANT NOW
- ☐ MENOPAUSAL SYMPTOMS
- ☐ HEAVY PERIODS
- ☐ IRREGULAR PERIODS

ENDOCRINE

- ☐ INCREASED THIRST
- ☐ INCREASED URINATION
- ☐ FATIGUE
- ☐ STEROID USE

HEMATOLOGIC/LYMPHATIC

- ☐ PAST BLOOD TRANSFUSION
- ☐ SWOLLEN/TENDER LYMPH NODE
- ☐ ANEMIA
- ☐ BLEEDING DISORDER
- ☐ BRUISE EASILY

MUSCULOSKELETAL

- ☐ JOINT PAIN
- ☐ JOINT STIFFNESS/SWELLING
- ☐ BACK PAIN
- ☐ NECK PAIN
- ☐ DIFFICULTY WALKING

ONCOLOGIC

- ☐ CHEMOTHERAPY
- ☐ RADIATION

GASTROINTESTINAL

- ☐ DIFFICULTY SWALLOWING
- ☐ PAINFUL SWALLOWING
- ☐ FILL UP QUICKLY AT MEALS
- ☐ NAUSEA OR VOMITING
- ☐ ABDOMINAL PAIN
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ BLOATING
- ☐ GAS
- ☐ INCOMPLETE EVACUATION OF BOWELS
- ☐ BLOOD IN STOOL OR ON TOILET PAPER
- ☐ LOSS OF CONTROL OF BOWEL
- ☐ BOWEL HABIT CHANGE
- ☐ BLEEDING
- ☐ ANAL PAIN
- ☐ ANAL ITCHING

☐ **NEUROLOGICAL**

- ☐ FREQUENT HEADACHES
- ☐ NUMBNESS
- ☐ FOCAL WEAKNESS
- ☐ USE OF CANE/WALKER
- ☐ FAINTING/BLACKOUTS
- ☐ LOSS OF FUNCTION

☐ **PSYCHIATRIC**

- ☐ EXCESSIVE SADNESS
- ☐ EXCESSIVE NERVOUSNESS
- ☐ INSOMNIA

☐ **INTEGUMENTARY**

- ☐ NEW RASH
- ☐ ITCHING
- ☐ EASY BRUISING
- ☐ SKIN CANCER

☐ **ADDITIONAL COMMENTS**