

Alma|Gastroenterology



History and Physical

First Name	Last Name	Date of Birth	Gender	Age
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Reason for today's visit: _____
Have you ever had a colonoscopy screening? If so, when? _____
Have you ever had a colonoscopy or EGD? _____

Medication:

Are you currently taking any blood thinners? _____
Are you allergic to any medication? _____

Please list any medication you are taking below:

Medication:	Dose:	How Often:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____

Surgery

Please list any surgery or procedure you have had below:

Surgery:	When:
1. _____	_____
2. _____	_____
3. _____	_____

Social

Do you smoke cigarettes? If so, how many packs a day? _____
Do you drink alcohol? If so, how often? _____
Do you drink caffeine? If so, how often? _____

Family History

Disease	Yes	No	Relationship to patient	Comment
Colon Cancer				
Colon Polyps				
Liver Disease				
Crohn's Disease				
Ulcerative Colitis				
Diabetes				
Heart Problems				
High Blood Pressure				
Diabetes				
Stroke				
Other Cancer				

Past Medical Illness

	Yes	No		Yes	No
Heart Disease			Blood Transfusions		
Chest Pain			High Blood Pressure		
Hepatitis			Diabetes		
Liver Problems			Cancer, if so list below		
Kidney Problems					

Present Medical Illness

	Yes	No		Yes	No
Constipation			Heartburn		
Diarrhea			Bloating		
Rectal Bleeding			Belching		
Black, Tarry Stools			Weight Loss		
Anal Pain with BMs			Loss of Appetite		
Change in BMs			Nausea		
Yellow Skin			Vomiting Blood		
Abdominal Pain					