



## Diagnostic Studies/Tests

- None
- |  |   |   |   |   |
|--|---|---|---|---|
| <input type="radio"/> Blood Work<br>When: _____                | <input type="radio"/> Colonoscopy<br>When: _____        | <input type="radio"/> CT Scan of the Abdomen<br>When: _____ | <input type="radio"/> Liver Biopsy<br>When: _____ | <input type="radio"/> MRI of the Abdomen<br>When: _____ |
| <input type="radio"/> Ultrasound of the Abdomen<br>When: _____ | <input type="radio"/> Upper GI Endoscopy<br>When: _____ | <input type="radio"/> Upper GI Series<br>When: _____        | <input type="radio"/> Other<br>When: _____        |   |

## Past or Present Medical Conditions

- None
- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="radio"/> Anemia                   | <input type="radio"/> Angina Pectoris                        | <input type="radio"/> Asthma                               | <input type="radio"/> Atrial Fibrillation | <input type="radio"/> Bleeding Disorder |
| <input type="radio"/> Blood Transfusion        | <input type="radio"/> Breast Cancer                          | <input type="radio"/> Cancer, Other (Specify)              | <input type="radio"/> Colon Cancer        | <input type="radio"/> Colon Polyps      |
| <input type="radio"/> Congestive Heart Failure | <input type="radio"/> Diabetes, adult onset without insulin. | <input type="radio"/> Diabetes Mellitus, Insulin Dependent | <input type="radio"/> Emphysema           | <input type="radio"/> Endocarditis      |
| <input type="radio"/> Glaucoma                 | <input type="radio"/> Gout                                   | <input type="radio"/> Hepatitis A                          | <input type="radio"/> Hepatitis B         | <input type="radio"/> Hepatitis C       |
| <input type="radio"/> Hypertension             | <input type="radio"/> Hyperthyroidism                        | <input type="radio"/> Hypothyroidism                       | <input type="radio"/> Jaundice            | <input type="radio"/> Kidney Stones     |
| <input type="radio"/> Myocardial infarction    | <input type="radio"/> Rheumatic Fever                        | <input type="radio"/> Seizures                             | <input type="radio"/> Sleep Apnea         | <input type="radio"/> Ulcer Disease     |
| <input type="radio"/> Other (Specify)          |  |  |   |   |

## Previous Procedures

- None
- |  |  |  |  |   |
|--|--|--|--|---|
| <input type="radio"/> Aortic Aneurism Repair<br>When: _____          | <input type="radio"/> Appendectomy<br>When: _____                        | <input type="radio"/> Bowel Surgery<br>When: _____   | <input type="radio"/> Cholecystectomy<br>When: _____ | <input type="radio"/> Coronary Artery Bypass Grafting (CABG)<br>When: _____ |
| <input type="radio"/> Coronary Artery Stent Placement<br>When: _____ | <input type="radio"/> Fundoplication/Hiatal Hernia Repair<br>When: _____ | <input type="radio"/> Hip Replacement<br>When: _____ | <input type="radio"/> Hysterectomy<br>When: _____    | <input type="radio"/> Inguinal herniorrhaphy<br>When: _____                 |
| <input type="radio"/> Knee Replacement<br>When: _____                | <input type="radio"/> Obesity Surgery<br>When: _____                     | <input type="radio"/> Stomach Surgery<br>When: _____ | <input type="radio"/> Ulcer Surgery<br>When: _____   | <input type="radio"/> Umbilical Hernia<br>When: _____                       |
| <input type="radio"/> Heart Valve Replacement<br>When: _____         | <input type="radio"/> Other<br>When: _____                               |  |  |   |

## Social History

Occupation: \_\_\_\_\_ Number of Children: \_\_\_\_\_

### Marital Status

Single       Married       Divorced       Widowed

### Alcohol

None

| Type                          | Quantity | Frequency |
|-------------------------------|----------|-----------|
| <input type="radio"/> Alcohol | _____    | _____     |
| <input type="radio"/> Beer    | _____    | _____     |
| <input type="radio"/> Liquor  | _____    | _____     |
| <input type="radio"/> Wine    | _____    | _____     |

### Caffeine

None  
 Coffee daily       Coffee  $\geq$  3 cups daily       Tea

### Tobacco

**Smoking Status**       Current every day smoker       Current some day smoker       Former smoker       Never smoker  
 Smoker, current status unknown       Unknown if ever smoked

| Type                             | Started | Quit  | Quantity | Frequency |
|----------------------------------|---------|-------|----------|-----------|
| <input type="radio"/> Cigar      | _____   | _____ | _____    | _____     |
| <input type="radio"/> Cigarettes | _____   | _____ | _____    | _____     |
| <input type="radio"/> Pipe       | _____   | _____ | _____    | _____     |

### Drug Use

None

| Type                                    | Quantity | Frequency |
|---|----------|-----------|
| <input type="radio"/> Cocaine           | _____    | _____     |
| <input type="radio"/> Intravenous Drugs | _____    | _____     |
| <input type="radio"/> Marijuana         | _____    | _____     |

### Exercise

None

| Type  | Quantity | Frequency |
|-------|----------|-----------|
| _____ | _____    | _____     |
| _____ | _____    | _____     |

# Family Medical History

No knowledge of family history

No family history of  Colon Cancer

Colon Polyps

## Diagnoses

### Family History

|                                 | Mother                | Father                | Sister                | Brother               | Daughter              | Son                   | Maternal Grandmother  | Paternal Grandmother  | Maternal Grandfather  | Paternal Grandfather  | Other                 |
|---------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Breast Cancer                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Celiac Disease (Gluten Allergy) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Cirrhosis                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Colon Cancer                    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Colon Polyps                    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Crohn's Disease                 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Diabetes Mellitus               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Esophageal Cancer               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Gallstones                      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Hemochromatosis                 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Liver Disease                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Pancreatic Cancer               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Stomach Cancer                  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Ulcerative Colitis              | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Ulcer Disease                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

# Review Of Systems

|  |           |  |           |  |           |
|--|-----------|--|-----------|--|-----------|
| <b>Constitutional</b><br><input type="radio"/> None<br>fatigue<br>fever<br>loss of appetite<br>malaise<br>sweats<br>weight gain<br>weight loss   | Yes<br>No | <b>Respiratory</b><br><input type="radio"/> None<br>cough<br>shortness of breath<br>wheezing   | Yes<br>No | <b>Musculoskeletal</b><br><input type="radio"/> None<br>back pain<br>joint pain<br>muscle weakness   | Yes<br>No |
| <b>Integumentary</b><br><input type="radio"/> None<br>itching<br>rash  | Yes<br>No | <b>Gastrointestinal</b><br><input type="radio"/> None<br>abdominal pain<br>abdominal swelling or distention<br>belching<br>change in bowel habits<br>constipation<br>diarrhea<br>flatulence<br>food intolerance<br>food sticking<br>gas<br>heartburn<br>incontinence of stool<br>nausea<br>painful swallowing<br>rectal bleeding<br>stomach cramps<br>trouble swallowing<br>vomiting<br>vomiting blood | Yes<br>No | <b>Neurological</b><br><input type="radio"/> None<br>dizziness<br>fainting<br>frequent headaches<br>migraine<br>numbness or tingling<br>tremors    | Yes<br>No |
| <b>ENMT</b><br><input type="radio"/> None<br>change in voice<br>hearing trouble<br>loss of vision<br>nose bleeding<br>sore throat  | Yes<br>No | <b>Genitourinary</b><br><input type="radio"/> None<br>blood in the urine<br>frequent urinary infections<br>frequent urination<br>uncomfortable urination<br>urethral discharge or incontinence<br>urination during the night   | Yes<br>No | <b>Psychiatric</b><br><input type="radio"/> None<br>anxiety<br>depression<br>difficulty sleeping<br>hallucinations<br>nervousness<br>panic attacks | Yes<br>No |
| <b>Cardiovascular</b><br><input type="radio"/> None<br>ankle swelling<br>chest pain<br>irregular heart beat<br>shortness of breath with exertion<br>trouble breathing while lying down | Yes<br>No |  |           | <b>Hematologic/Lymphatic</b><br><input type="radio"/> None<br>bleeding gums<br>easy bruising<br>enlarged lymph nodes<br>prolonged bleeding         | Yes<br>No |
|  |           |  |           | <b>Allergic/Immunologic</b><br><input type="radio"/> None<br>HIV exposure<br>persistent infections<br>strong allergic reactions or hives           | Yes<br>No |

## Pharmacy

Name: \_\_\_\_\_

## Reviewed with

Patient     
  Parent     
  Guardian     
  Not Present