New/New 3 Year Patient:

Name: _____ When was your last Colonoscopy? _____

Review of Systems: (Please check all that apply)

Constitutional:	Respiratory:	Cardiovascular:	Hematologic:	Immunologic:
___Chills	___Dyspnea	___Chest Pain	___Easy Bruising	___Asthma
___Fever	___Frequent Cough	___Leg Swelling	___Easy Bleeding	___Immunosuppression
___Malaise	___Pleuritic Pain	___Palpitations	___Lymphadenopathy	___Food Allergies
___Weight Loss	___Wheezing			___ Seasonal Allergies
				___Chemicals at work

Gastrointestinal:

___Abdomen pain	___Constipation	___Bloody Vomit	___Nausea
___Altered Bowel Habits	___Diarrhea	___Bowel Incontinence	___Rectal Bleeding
___Black Stools	___Decreased Appetite	___Jaundice	___Reflux
___Bloating	___Difficulty Swallowing	___Heartburn	___Vomiting
___Blood in stools	___Excessive Gas	___Painful Swallowing	___Weight Loss

Allergies to medicine and reaction:

_____ _____

_____ _____

_____ _____

Medications: (Please Include Strength and Frequency)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Previous/current medical problems and surgeries:

_____ _____

_____ _____

_____ _____

Social History:

Do you use tobacco? Yes___ No___ How much? _____ Type? _____

Do you use alcohol? Yes___ No___ How Often? _____ Type? _____

Do you use caffeine? Yes___ No____ How often? _____ Type? _____

Have you ever used drugs? Yes ____ No ____ Formerly____ Type? _____

GI Diseases that run in your family:

Father: Alive____ Deceased____ Conditions: _____

Mother: Alive_____ Deceased_____ Conditions: _____

Brother(s): Alive_____ Deceased_____ Conditions: _____

Sister(s): Alive____ Deceased _____ Conditions: _____

Grandparents: Alive_____ Deceased _____ Conditions: _____

Son(s): Alive: _____ Deceased _____ Conditions: _____

Daughter(s): Alive: _____ Deceased: _____ Conditions: _____