

NAME: _____ D.O.B _____ TODAY'S DATE _____

PHARMACY: _____ LOCATION: _____

REFERRING PROVIDER: _____ PRIMARY CARE PROVIDER: _____

REASON FOR YOUR VISIT TODAY? _____

STAFF USE ONLY

HT _____ WT: _____ T: _____ P: _____ R: _____ B/P: _____ NURSE INITIALS: _____

MEDICATIONS

MEDICATION: _____ DOSE: _____ MEDICATION: _____ DOSE: _____

MEDICATION: _____ DOSE: _____ MEDICATION: _____ DOSE: _____

MEDICATION: _____ DOSE: _____ MEDICATION: _____ DOSE: _____

MEDICATION: _____ DOSE: _____ MEDICATION: _____ DOSE: _____

ALLERGIES

ALLERGY TO: _____ REACTION: _____ ALLERGY TO: _____ REACTION: _____

ALLERGY TO: _____ REACTION: _____ ALLERGY TO: _____ REACTION: _____

MEDICAL HISTORY: NONE _____ YES ___ ALLERGIES (ENVIROMENTAL) _____ YES ___ DEPRESSION _____

YES ___ HEART DISEASE _____ YES ___ DIABETES _____ YES ___ URINERY TRACK INFECTION _____

YES ___ HYPERTENSION _____ YES ___ THYROID DISORDER _____ YES ___ KIDNEY STONE _____

YES ___ HIGH CHOLESTEROL _____ YES ___ ANEMIA _____ YES ___ ENLARGED PROSTATE _____

YES ___ CONGESTIVE HEART FAILURE _____ YES ___ REFLUX _____ YES ___ CANCER _____

YES ___ BLOOD CLOT _____ YES ___ ULCER _____ YES ___ ARTHRITIS _____

YES ___ SLEEP APENA _____ YES ___ CROHN'S DISEASE _____ YES ___ OSTEOPOROSIS _____

YES ___ ASTHMA _____ YES ___ ULCERATIVE COUTIS _____ YES ___ FIBROMYALGIA _____

YES ___ HEADACHES _____ YES ___ COLON POLYP(s) _____ YES ___ OTHER _____

YES ___ COPD _____ YES ___ IRRITABLE BOWELL SYNDROME _____ _____

YES ___ STROKE _____ YES ___ HEPATITIS _____ _____

YES ___ GLOUCOMA _____ YES ___ ANXIETY _____ _____

DATE OF LAST MENSTRUAL CYCLE _____

NAME: _____ D.O.B _____ TODAY'S DATE _____

SURGERIES NONE []

TYPE: _____ DATE: _____ TYPE: _____ DATE: _____

TYPE: _____ DATE: _____ TYPE: _____ DATE: _____

TYPE: _____ DATE: _____ TYPE: _____ DATE: _____

TYPE: _____ DATE: _____ TYPE: _____ DATE: _____

Have you ever had a colonoscopy? _____ If Yes, when _____, where _____, doctor _____

Have you ever had a EGD ? _____ If Yes, when _____, where _____, doctor _____

ALCOHOL USE: NONE _____ SOCIAL _____ MODERATE (2 DRINKS PER DAY OR LESS) _____ HEAVY (3 DRINKS OR MORE PER DAY) _____
RECOVERING ALCHOLIC _____ DATE OF LAST DRINK _____

TABACCO USE: NONE _____ CIGARETTES—HOW MANY PACKS PER DAY _____ CIGARS HOW MANY PER DAY _____ PIPE _____ OTHER _____

ILLICIT DRUG USE: NONE _____ PREVIOUS USE _____ PRODUCT _____ DATE LAST USED _____ TATTOOS: NONE _____ YES _____

FAMILY HEALTH HISTORY:

YES _____ COLON CANCER – WHO _____ DIAGNOSED AT WHAT AGE _____

YES _____ COLON POLYP(S) – WHO _____ DIAGNOSED AT WHAT AGE _____

YES _____ ULCERATIVE COLITIS – WHO _____

YES _____ CROHN'S COLITIS – WHO _____

YES _____ PEPTIC ULCER DISEASE YES _____ GALBLADDER DISEASE

YES _____ CELIAC DISEASE YES _____ LIVER DISEASE
