	Yes	No
Arthritis	❑	❑
Glaucoma	❑	❑
Stroke	❑	❑

Other ______________________________

____

Operations: (List and indicate approximate year)

____
____
____
____
____
____

Endoscopic Procedures	Date
Upper endoscope	________
Esophageal dilation	________
Flexible sigmoidoscopy	________
Colonoscopy	________
ERCP	________

Hospitalizations (other than operations): List reasons and dates.

____
____
____
____

Diagnostic X-rays in the last one year: Please list and give dates

____
____
____

Recent Bloodwork?

When? Where?

____
____

Are your immunizations up-to-date? Yes No

Personal Habits

1. Check if you regularly smoke or have smoked:

❑ Cigarettes packs per day _____ ❑ Pipe ❑ Cigars

How long have you been smoking? ________ years

When did you quit? ____________________

2. Check if you regularly drink or have drunk alcohol:

❑ Never ❑ Rarely ❑ Occasionally

❑ Hard liquor 1-3 oz. per day ❑ over 3 oz. per day ❑

❑ Beer 1-2 bottles per day ❑ 3 or more bottles per day ❑

❑ Wine 1-2 glasses per day ❑ 3 or more glasses per day ❑

3. Check if you use or have used illegal drugs: ❑ Now ❑ Ever

Which ones? ______________________________

____

FAMILY HISTORY

Have any of your blood relations had colitis or Crohn's Disease?
Who, age at diagnosis?______________________________

Have any of your blood relations had colon cancer?
Who, age at diagnosis?______________________________

Have any of your blood relations had polyps in the colon?
Who, age at diagnosis?______________________________

Have any of your blood relations had pancreatic or gastric cancer?
Who, age at diagnosis?______________________________

Have any of your blood relations had uterine, ovarian, small bowel, or urinary tract cancer?
Who, what kind, age at diagnosis? ______________________________

Have any of your blood relations had other cancers?
Who, age at diagnosis?______________________________

Have any of your blood relations had liver disease?
Who, age at diagnosis?______________________________

REVIEW OF SYSTEMS

Do you have now or have you had difficulties with:

	Yes	No
General		
Weight loss	❑	❑
Weight gain	❑	❑
Fever	❑	❑
Chills	❑	❑
Sweats at night	❑	❑
Excessive fatigue	❑	❑
Respiratory		
Chronic Cough	❑	❑
Shortness of breath	❑	❑
Snoring loudly	❑	❑
Cardiovascular		
Chest pain	❑	❑
Difficulty breathing when lying down	❑	❑
Swelling of ankles	❑	❑
Heart beating fast or irregularly	❑	❑
Gastrointestinal		
Poor appetite	❑	❑
Heartburn or reflux	❑	❑
Trouble swallowing	❑	❑
Indigestion	❑	❑
Abdominal pain or discomfort	❑	❑
Inability to eat a normal amount of food	❑	❑
Feeling bloated or distended, particularly after eating	❑	❑
Nausea or vomiting	❑	❑
Vomiting blood	❑	❑
Black or tarry stools	❑	❑
Passing blood from your rectum	❑	❑
Mucous in stool	❑	❑
Recent changes in bowel habits	❑	❑
Diarrhea	❑	❑
Constipation	❑	❑
Frequent need for laxatives	❑	❑
Taking aspirin, arthritis medications, or non prescription pain medications	❑	❑
Endocrine		
Feeling hot	❑	❑
Feeling cold	❑	❑
Hair loss	❑	❑
Eyes		
Visual loss	❑	❑
Visual blurring	❑	❑

	Yes	No
HENT		
Sore throat	❑	❑
Recurrent sinusitis	❑	❑
Lump in throat	❑	❑
Hoarseness	❑	❑
Allergy/Immune		
Nasal stuffiness	❑	❑
Runny nose	❑	❑
Post nasal drip	❑	❑
Musculoskeletal		
Joint pain	❑	❑
Muscle pain	❑	❑
Back pain	❑	❑
Gynecology		
Irregular periods	❑	❑
Painful periods	❑	❑
Excessive menstrual bleeding	❑	❑
Pelvic pain	❑	❑
GU		
Burning or discomfort with urination	❑	❑
Difficulty urinating	❑	❑
Testicular pain	❑	❑
Groin pain	❑	❑
Hernias	❑	❑
Dermatologic		
Itching	❑	❑
Rash	❑	❑
Liver		
History of jaundice	❑	❑
Ever transfused/ Blood products?	❑	❑
Fluid in abdomen	❑	❑
Enlarged liver	❑	❑
Exposure to hepatitis	❑	❑
Needle sticks	❑	❑
Refusal for blood donation	❑	❑
Neurologic		
Numbness or tingling in hands or feet	❑	❑
Headaches	❑	❑
Weakness	❑	❑
Psych		
Depression	❑	❑
Anxiety	❑	❑
Nervous breakdown in past	❑	❑
Suicide attempts in past	❑	❑
Feeling of impending doom	❑	❑
Excessive stress at work or home	❑	❑

INTAKE SHEET FOR SCREENING COLONOSCOPY
OR COMBINED PROCEDURE/CONSULTATIONS

The following medical conditions may place you at higher risk for endoscopic procedures.
Please check if you have any of the following:

	Yes	No
Do you take iron tablets?	❑	❑
Joint replacement or aortic surgery in the last 6 months?	❑	❑
Artificial heart valve, significant heart murmurs, history of rheumatic fever, or infected heart valve (endocarditis)?	❑	❑

Are you on blood thinners? (Aspirin, Coumadin, arthritis medications, over the counter pain medications)

For what and which kind? ______________________

	Yes	No
Excessive or poorly controlled bleeding with dental or surgical procedures?	❑	❑
Severe high blood pressure?	❑	❑
Frequent chest pain due to heart disease?	❑	❑

Instructions from Doctor if yes to any of the above lines: ______________________

____

____

____

PATIENT INFORMATION

DATE ______________________

PATIENT'S NAME ______________________, ______________________, __________

PRIMARY PHYSICIAN ______________________ OTHER PHYSICIANS ______________________

BIRTHDATE ______/______/______ AGE __________ OCCUPATION ______________________

MARITAL STATUS: ❑ Married ❑ Single ❑ Separated ❑ Divorced ❑ Widowed

REASON FOR CONSULTATION ______________________

____

____

ARE YOU ALLERGIC TO ANY MEDICATIONS? Yes No

If yes, please list medications and the reactions you had:

____

____

____

Please list all of your medications with the doses and frequency:
(continue on back if necessary)

e.g.. Lasix 40mg 1 per day

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

PAST HISTORY (Personal)

GI Illnesses

Do you have now, or have you ever been told that you have:

	Yes	No
Hiatal Hernia	❑	❑
Esophageal Reflux	❑	❑
Stomach or Duodenal Ulcer	❑	❑
Esophageal Stricture/Narrowing	❑	❑
Pancreatitis	❑	❑
Gallstones/Gallbladder Disease	❑	❑
Gastrointestinal Bleeding	❑	❑
Alcoholism	❑	❑
Irritable Bowel Syndrome	❑	❑
Colon Polyps or Cancer	❑	❑
Colitis or Crohn's Disease	❑	❑
Diverticulosis or Diverticulitis	❑	❑
Liver Disease	❑	❑
Hepatitis A, B, or C	❑	❑
Abnormal Liver Tests	❑	❑
Cirrhosis of the Liver	❑	❑
	❑	❑

Medical Illnesses

Do you have now, or have you ever been told that you have:

	Yes	No
Cardiac Pacemaker	❑	❑
Automatic Defibrillator	❑	❑
Thyroid Disease	❑	❑
Heart Attack	❑	❑
Angina	❑	❑
Congestive Heart Failure	❑	❑
Heart Murmur	❑	❑
Artificial Heart Valve	❑	❑
High Blood Pressure	❑	❑
Heart Arrythmia	❑	❑
Kidney Disease	❑	❑
Organ Transplant	❑	❑
Asthma	❑	❑
Emphysema	❑	❑
Sleep Apnea	❑	❑
Anemia	❑	❑
Cancer	❑	❑
When? What kind? __________		
Diabetes	❑	❑