

**PATIENT MEDICAL HISTORY FORM**

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

**Do you take any medication, herbal remedies, or over the counter medications? Y N**  
**(If YES, please list)**

\_\_\_\_\_

**Are you allergic to any medications? Y N (If YES, please list)**

\_\_\_\_\_

**Have you had Flexible sigmoidoscopy or colonoscopy Y N (If YES, When?)**

\_\_\_\_\_

**List ALL medical condition for which you are under the care of a physician currently:**

\_\_\_\_\_

**List ALL surgeries that you have had and the dates:**

\_\_\_\_\_

Family History: (Circle any that apply to blood relatives) Diabetes, High Blood Pressure, Heart Disease, Colon Cancer, Colon Polyp Disease, Ulcer Disease, Colitis, Crohn's Disease, Stroke, Gout, Epilepsy, Kidney Disease, Anemia, Asthma, Arthritis, Liver Disease, Other:

\_\_\_\_\_

**Review of Systems: (Circle symptoms that you are experiencing at this time)**

**No circle indicates a negative response.**

- |                      |                |                  |                   |
|----------------------|----------------|------------------|-------------------|
| Lack of energy       | Vision changes | Chest pain       | Trouble sleeping  |
| Post nasal drip      | Palpitations   | Weight loss      | Swollen legs      |
| Sore throat          | Weight gain    | Voice Change     | Diarrhea          |
| Shortness of breath  | Constipation   | Excessive thirst | Painful menses    |
| Coughing up blood    | Chronic cough  | Vomiting         | Nausea            |
| Rectal Bleeding      | Abdominal pain | Joint swelling   | Loss of appetite  |
| Pregnancy            | Heartburn      | Joint redness    | Numbness          |
| New skin rash        | Joint pain     | Depression       | Heartburn         |
| Difficult Swallowing | Regurgitation  | Back Pain        | Tingling          |
| Anxiety              | Sour taste     | Muscle Aches     | Painful Urination |

Date: \_\_\_\_\_ MD Initials  
Date: \_\_\_\_\_ MD Initials

Date: \_\_\_\_\_ MD Initials  
Date: \_\_\_\_\_ MD Initials

Date: \_\_\_\_\_ MD Initials  
Date: \_\_\_\_\_ MD Initials