

PLEASE COMPLETE BOTH SIDES



Patient's Name : _____ Date of Birth : (D/M/Y) ___ / ___ / ___

Gender : Female Male Languages Spoken : _____

Reason for Appointment : _____

Family History :

Any members of your family diagnosed with colon/ rectal cancer ? Yes No

If **Yes** please specify : _____

Any members of your family have Colon Polyps ? Yes No

If **Yes** please specify : _____

Any members of your family diagnosed with IBD- Crohns Disease or Ulcerative Colitis ? Yes No

If **Yes** please specify : _____

Medical History :

HEIGHT : _____ (CM/IN), **WEIGHT :** _____ (KG/LBS)

Diagnosis	Yes	No	Diagnosis	Yes	No
High Blood Pressure			Asthma		
Heart Disease/ Heart Attack			Sleep Apnea / Use CPAP Machine		
Atrial Fibrillation			COPD/ Emphysema		
Stroke / TIA			Hypothyroidism / Hyperthyroid		
Seizures / Epilepsy			Glaucoma		
Multiple Sclerosis (MS)			Crohns Disease/ Ulcerative Colitis		
Diabetes			HIV / AIDS		
Arthritis			Hepatitis A, B, or C (Circle)		
Liver Disease – Specify _____			Kidney Disease- Specify _____		
Lung Disease- Specify _____			Cancer Type : _____ Treatment : Chemo, Radiation, Surgery (Circle)		

Please List any other medical conditions if not listed above :

Current Medications :

Medications	Yes	No	IF YES SPECIFY DOSE
Coumadin (Warfarin), Pradaxa, Xarelto, Eliquis			
Plavix, ASA (ie. Aspirin, Aggrenox)			
NSAIDS (ie. Advil, Celebrex, Naproxen)			

Please List prescribed and over the counter medications you take regularly

Medication :	Medication Dose :

***** Please attach pharmacy list to the form or write on the back of the sheet if more space is required**

Allergies :

Do you have allergies to Medications or Medical Products (ie. Latex, IV Contrast) ? Yes No

If **Yes** please specify : _____

Surgical History

CIRCLE THE ONES THAT APPLY :

Surgical Procedure :	Year of Procedure :	Surgical Procedure	Year of Procedure :
Appendectomy (Appendix Removed)		Pacemaker / Defibrillator	
Cholecystectomy (Gallbladder Removed)		Coronary Stent/ CABG (Bypass)	
Colonoscopy		Hernia Repair	
EGD (Upper Endoscopy)		Tonsillectomy	
C-Section		Bowel Resection	
Hysterectomy / Ovaries		Hemorrhoidectomy/ Hemorrhoid Banding	
Tubal Ligation			

Please List any other surgical procedures if not listed above :

Have you ever had Chest Pain / Angina (Chest pain related to your heart) ? Yes No

Do you experience gastric reflux, heartburn, or indigestion ? Yes No (If yes, circle which applies)

Do you use alcohol? Yes No

If **Yes** : How frequently ? _____

Do you smoke? Yes No

If **Yes** : How long have You been smoking for ? _____ How many per Day ? _____

Are you an ex-smoker ? Yes No

If **Yes** : When did you quit ? _____ (Month/Year)

Do you use street drugs ? Yes No

If **Yes** please specify : _____

Do you have dentures/ caps/ crowns/ or bridges? Yes No (If yes, circle which applies)

Do you have any loose teeth? Yes No

Is there any possibility of pregnancy Yes No

Have **You** ever had any problems with Anesthesia (i.e Nausea/Vomitting, Prolonged Recovery, Reactions) ?

If **Yes** please specify : _____

Have any of your family members ever had any problems with Anesthesia (i.e. Malignant Hyperthermia) ?

If **Yes** please specify : _____