Precision DIGESTIVE CARE

Your name _____ Date _____

What is the main reason for your visit today? _____

Please list any current medical conditions you have (example: diabetes) _____

_____

Please list any operations you have had _____

Please list any medical problems that run in your family _____

Does anyone in your family have colon or rectal cancer? _____

Have you ever had a colonoscopy or endoscopy in the past? If so, when? _____

Do you smoke? Yes No Quit in _____ Do you drink alcohol? Yes No Socially Quit

What is your occupation? _____

How did you hear about our office? _____

Please check any of the following that may apply to you

- ☐ Anemia
- ☐ Anxiety
- ☐ Atrial fibrillation
- ☐ Blood in stool
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Constipation
- ☐ COPD
- ☐ Defibrillator
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Emphysema
- ☐ Fever
- ☐ Frequent Urination
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart murmur
- ☐ Heart stent
- ☐ Heart surgery
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ High cholesterol
- ☐ Irregular periods
- ☐ Irregular pulse
- ☐ Joint pains
- ☐ Kidney stones
- ☐ Migraines
- ☐ Nausea
- ☐ Pneumonia
- ☐ Pacemaker
- ☐ Skin rash
- ☐ Sleep apnea
- ☐ STD
- ☐ Swallowing problem
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ UTI
- ☐ Vomiting
- ☐ Weight loss

MEDICATIONS **(names only)**

☐ See attached list