Date: ____________________

Name: ________________________________ Age: __________ Gender: _______ Race: ______________

Have you ever been seen by a physician in our practice? Yes No If Yes, when________

Which physician are you scheduled to see today? ______________________________________

Which physician referred you to our office for consultation? ______________________________________

Who is your primary care physician? ______________________________________

PRESENTING COMPLAINT Briefly describe the reason for your visit.

REVIEW OF SYSTEMS Please check any symptoms you are **currently** experiencing.

Digestive Tract
- ☐ Nausea/Vomiting
- ☐ Trouble swallowing
- ☐ Painful swallowing
- ☐ Heartburn
- ☐ Indigestion/belching
- ☐ Abdominal pain
- ☐ Bloating/gas
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Fecal incontinence
- ☐ Constipation
- ☐ Blood in stool
- ☐ Black stools
- ☐ Hemorrhoids
- ☐ Rectal Pain/itching

General
- ☐ Change in appetite
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Night sweats
- ☐ Weight loss _______lbs
- ☐ Weight gain _______lbs

Heart/Lungs
- ☐ Cough
- ☐ Coughing blood
- ☐ Sputum production
- ☐ Wheezing
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Swelling in legs
- ☐ Heart murmur
- ☐ Palpitations

Head
- ☐ Headaches
- ☐ Double vision
- ☐ Eye pain
- ☐ Sensitivity to light
- ☐ Vision loss
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Nosebleeds
- ☐ Nasal congestion
- ☐ Sinusitis
- ☐ Bleeding gums

Genitourinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Kidney stones
- ☐ Urinary incontinence

Endocrine
- ☐ Enlarged thyroid
- ☐ Hair loss

Neurological
- ☐ Dizziness
- ☐ Loss of memory
- ☐ Numbness/tingling
- ☐ Tremor

Skin
- ☐ Itching
- ☐ Jaundice
- ☐ Lesions
- ☐ Rash

Musculoskeletal
- ☐ Back pain
- ☐ Joint pain
- ☐ Muscle cramps
- ☐ Neck pain
- ☐ Neck stiffness

Blood
- ☐ Anemia
- ☐ Blood transfusion
  Date:
- ☐ Easy bleeding/bruising
- ☐ Enlarged lymph nodes

Immune
- ☐ Allergies, food
- ☐ Allergies, environmental/seasonal

Women Only
- ☐ Breast lump
- ☐ Breast pain
- ☐ Abnormal menstrual cycle
- ☐ Vaginal discharge

Name: ______________________________ Date: ____________________

HEALTHCARE MAINTENANCE

If you are 50 years of age or older, have you had the following?

Colonoscopy	☐ Yes	☐ No	Date: ________
Flexible Sigmoidoscopy	☐ Yes	☐ No	Date: ________
Barium Enema	☐ Yes	☐ No	Date: ________
Stool Test for Blood (Hemoccult)	☐ Yes	☐ No	Date: ________
Prostate Exam and PSA (Blood test)	☐ Yes	☐ No	Date:

Have you ever had an upper GI series or gastroscopy?	☐ Yes	☐ No	Date: ________

Have you had the following vaccinations:

Influenza (Flu)	☐ Yes	☐ No	Date: ________
Pneumococcal	☐ Yes	☐ No	Date: ________
Hepatitis A	☐ Yes	☐ No	Date: ________
Hepatitis B	☐ Yes	☐ No	Date: ________

PAST MEDICAL HISTORY Please check the following medical conditions which apply to **you**.

- ☐ Colon polyps
- ☐ Blood Thinner
  - Type: ____________
- ☐ Heart problems
  - ☐ AFib
  - ☐ CHF
  - ☐ Stents ________
- ☐ Stroke
- ☐ COPD
- ☐ High blood pressure
- ☐ Sleep apnea
- ☐ Asthma
- ☐ Seizures
- ☐ Cancer **Type:** ____________________
- ☐ Thyroid problems ____________________
- ☐ Diabetes
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Hepatitis **Type:**
- ☐ Other ____________________

PAST SURGICAL HISTORY Please check the following surgeries that **you** have had in the past.

Surgery	Date
☐ Cholecystectomy (Gallbladder removal)	______
☐ Colon Surgery	______
☐ Appendectomy	______
☐ Cancer	______
☐ Diverticular disease	______
☐ IBD (Crohn's, Ulcerative Colitis)	______
☐ Bleeding	______
☐ Obstruction	______
☐ Perforation	______
☐ Hemorrhoidectomy	______
☐ Other: ____________________	______
☐ Stomach Surgery	______
Type: ☐ Lap Nissen	______
☐ Ulcer disease	______
☐ Cancer	______
☐ Bariatric (weight loss surgery)	______
Type: ☐ Lap Band	______
☐ Gastric Sleeve	______
☐ RYGB	______
☐ Other	______
☐ Other ________________	______

Surgery	Date
☐ Pancreatic Surgery	______
☐ Liver Surgery	______
☐ Other GI Surgeries:	
______________________________	______
______________________________	______
______________________________	______
______________________________	______
______________________________	______
☐ Hysterectomy	
☐ Other Surgeries:	
______________________________	______
______________________________	______
______________________________	______
______________________________	______
______________________________	______

Name: ________________________________ Date: ____________________

FAMILY HISTORY ☐ Patient is adopted. Family history unknown.

Father's Age _____ If deceased, age at death and cause ____
Mother's Age _____ If deceased, age at death and cause ____

Total number of brothers and sisters you have had _______________

Do you have any **immediate family members** that have ever had the following:

☐	Colon Polyps	Relative:	__________	Age at Diagnosis:	_____
☐	Colon Cancer	Relative:	__________	Age at Diagnosis:	_____
☐	Liver Disease	Relative:	__________	Age at Diagnosis:	_____
☐	Diabetes	Relative:	__________	Age at Diagnosis:	_____
☐	Heart Disease	Relative:	__________	Type of Heart Disease:	__________
☐	Other Cancers	Relative:	__________	Type of Cancer:	__________
☐		Relative:	__________	Type of Cancer:	__________
☐	Other Illnesses	Relative:	__________	Type of Illness:	__________
		Relative:	__________	Type of Illness:	__________

SOCIAL HISTORY

What city do you live in? ________________________
Occupation? ________________________

Marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Number of children? ____________

Do you smoke/chew tobacco? ☐ Yes ☐ No ☐ Former ☐ Social
How many years? ☐ ________
Packs per day? ☐ ________

Do you drink alcohol? ☐ Yes ☐ No ☐ Former ☐ Social
Number of drinks? ☐ ________

Have you ever used illicit/intravenous drugs? ☐ Yes ☐ No
Have you ever snorted drugs? ☐ Yes ☐ No
Have you ever had a body piercing? ☐ Yes ☐ No
Have you ever had a tattoo? ☐ Yes ☐ No

Name: ________________________________ Date: ____________________

MEDICATIONS List all prescription, over the counter and herbal medications you are taking including the dosage or number of pills per day.

☐ I currently take no medications.

Medication	Dose	Frequency

DRUG ALLERGIES List all medications to which you are allergic and the kind of reaction you experienced.

☐ I do not have any drug allergies.

Allergy	Reaction

Name: ______________________________ Date: ____________________

RISK ASSESSMENT FOR LYNCH AND HEREDITARY POLYPOSIS SYNDROME

Instructions: Please circle Y for those that apply to **YOU and/or YOUR FAMILY** (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

Mother	Paternal Uncle/Aunt
Father	Maternal Uncle/Aunt
Brother	First Cousins
Sister	Maternal Grandmother/Grandfather
Children	Paternal Grandmother/Grandfather
	Niece/Nephew

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of Lynch Syndrome and Hereditary Polyposis Syndrome. This information will help determine your hereditary cancer risk.

		Colon and Uterine Cancer	Self	Family Member	Age At Diagnosis
Y	N	Uterine (endometrial) cancer			
Y	N	Colorectal cancer			
Y	N	Ovarian, stomach, kidney/urinary tract, brain, small bowel, or pancreatic cancer			
Y	N	Two or more Lynch syndrome cancers*			

		Polyposis Syndrome	Self	Family Member	Age At Diagnosis
Y	N	10 or more cumulative (lifetime) colorectal adenomas (colon polyps) in the family			
Y	N	Have you or any member of your family ever been tested for hereditary risk of cancer?			
		If yes, please explain:			

For office use only
- ☐ Candidate for further risk assessment and/or genetic testing
- ☐ Information given to patient to review
- ☐ Follow-up appointment scheduled Date: _______________
- ☐ Patient offered genetic testing:
  - ○ Accepted
  - ○ Declined

__________ Date

______________________________ Patient or Responsible Party Signature

______________________________ Physician Signature