Patient information	
Patient Name:	Date of birth: Age: SS#:
Street Address/ Apt #	Gender: ☐ Male ☐Female ☐Transgender
City, State, Zip:	Weight: Height:
Home telephone #:	Marital Status: ☐S ☐D ☐M ☐W ☐DP
Work #: Cell #:	Race:
Email address: Pharmacy name/phone#/address:	Occupation:
May we leave messages on your voice mail ? ☐ Yes ☐ No	
Name of legally responsible representative (if not self):	
Relationship to patient:	
Street address:	
City, State, Zip:	Telephone:
Insurance Information	
Primary insurance:	Primary insured Social Security #:
Name of primary insured:	Primary insured ID number:
Name of policy holder and DOB if different than patient being seen: Name: DOB:	Relationship of policy holder if different than patient being seen (C=Child, S=Spouse, O=Other)
Secondary insurance (if applicable)	Secondary insurance ID#
Referring Physician Information	
Physician Name:	Is this the primary care giver? ☐ Yes ☐ No
Street Address:	If not, name of PCP:
City, State, Zip:	Telephone:

Patient Medical History

ALLERGIES: list medication and reaction

Have you ever had a Colonoscopy ? Reason: Date:
☐ Yes ☐ No

Have you ever had an Upper GI endoscopy ? ☐ Yes ☐ No	Reason:	Date:

Past **Surgical** History:

Smoking History: ☐ Never ☐ Previous smoker ; Quit date:
☐ Current smoker (#PPD and years):

Blood thinners
Do you currently take: ☐ Coumadin (Warfarin) ☐ Plavix ☐ Aspirin

Family History:
☐ colon cancer ☐ colon polyps ☐ ulcers ☐ stomach cancer

Do you have a **personal history** of any of the following?

☐Arthritis	☐Hypertension (high blood pressure)
☐Asthma or lung disease	☐Hyperthyroidism
☐Cancer (other than gastrointestinal)	☐Hypothyroidism
☐Celiac disease	☐Irritable bowel syndrome
☐Colorectal cancer	☐Kidney disease or stones
☐Crohn's disease	☐Liver disease
☐Depression/anxiety	☐Osteoporosis/osteopenia
☐Diabetes	☐Pancreatitis
☐GERD/reflux	☐Sleep apnea/on CPAP machine
☐HIV disease	☐Stroke
☐Heart disease	☐Tuberculosis
☐Hepatitis B	☐Ulcer disease
☐Hepatitis C	☐Ulcerative colitis
☐High cholesterol	☐Autoimmune diseases