

Have you ever had a reaction to anesthesia?

_____ Nausea/Vomiting _____ Fever _____ Difficulty waking up _____ Heart Problems

Are there any family members that have had a reaction to anesthesia?

_____ Nausea/Vomiting _____ Fever _____ Difficulty waking up _____ Heart Problems

Dentures? _____ YES _____ NO

Have you had any x-rays, CT scans, MRI's or US within the last year? _____ YES _____ NO

If yes, where? _____ What for? _____ Date _____

Have you had any blood tests done within the last year? _____ YES _____ NO

If yes, where? _____ What for? _____ Date _____

HAVE YOU HAD ANY OF THE FOLLOWING DONE?	YES	NO	DATE
Stool blood test			
Rectal exam			
Sigmoidoscopy/Colonoscopy/Upper Endoscopy			

Personal History Colon Polyps? _____ YES _____ NO

Lactose intolerant? _____ YES _____ NO

Please answer the following:	YES	NO
Do you smoke? Packs per day _____ How long? _____		
X-smoker? Date quit? _____ Packs per day _____ How long? _____		
Do you drink alcohol? Drinks per day _____ How long? _____		
Have you ever used illegal drugs? What _____ When _____		

SOCIAL SETTING (Are there any significant stresses in your life?)

A. MARITAL STATUS

Married _____
Divorced _____
Single _____
Separated _____
Widowed _____

D. HOME ENVIRONMENT

Own home _____
Rent _____

B. EDUCATION – HIGHEST LEVEL

High School _____
Tech Training _____
Associated Degree _____
Bachelors Degree _____
Advanced Degree _____

E. WORK ENVIRONMENT

RETIRED _____

Company name _____
Position _____
Satisfaction _____ Stress _____

C. TRAVEL (within the last year)

Out of Illinois _____
Out of the US _____
If so, where _____

F. RACE

American Indian or Alaska Native _____
Asian _____
Black or African American _____
Hispanic or Latino _____
Native Hawaiian or Pacific Islander _____
White _____
Other _____

H. OTHER STRESSES

Financial problems? _____
Problems with children? _____
Recent death in the family? _____
Relatives living with you? _____
Serious illness in the family? _____
Serious illness in self? _____
Other significant stresses: _____

Do you have any of the following gastrointestinal symptoms:

	YES	NO		YES	NO		YES	NO
Heartburn			Vomiting blood			Blood on stool or tarry black stool		
Regurgitation/acid reflux			Abdominal Pain			Mucus in stool		
Difficulty swallowing			Passing excessive gas			Leaking stool/accidents		
Indigestion			Diarrhea			Hemorrhoids		
Increased belching/burping			Change of bowel habits			Jaundice (skin or whites of the eyes yellow)		
Change of appetite			Narrowing of stool			History of gall bladder disease		
Nausea			Constipation			Abdominal bloating		
Vomiting			Rectal itch			Significant weight change Gain _____ Loss _____		
						Number of pounds: _____ Over what time period: _____		

Do you have any of the following symptoms:

	YES	NO		YES	NO		YES	NO
Any rashes, sores, color changes or spots on skin			Frequent or painful urination			Leg cramps with walking		
Deafness or hearing loss			Numbness/tingling anywhere			Night sweats/hot flashes		
Frequent nose bleeds			Frequent headaches			Anxiety		
Chest pain or pressure			Fainting or dizzy spells			Apprehension		
Heart palpitations/fluttering			Convulsion or seizures			Depression		
Difficulty breathing			Double/blurred vision			Mood swings		
New cough			Change of color in hands or feet			Nervousness		
Blood in urine			Joint pain					

Do you take birth control pills? YES _____ NO _____

How many times have you been pregnant? _____ Any a ~~g~~ ~~m~~ ~~f~~ ~~l~~ ~~u~~ ~~y~~ ~~g~~ _____ Any abortions? _____

When was your last period? _____

When was your last Pap smear? _____

When was your last mammogram? _____

DO NOT WRITE IN THIS SPACE

TEMP _____ PULSE _____ RESPIRATION _____ B/P _____

WEIGHT _____ HEIGHT _____

**LIST MEDICATIONS: PRESCRIPTIONS INCLUDING BLOOD THINNERS, DIABETES PILLS,
& INSULIN (Bring medicines to the office with you)**

NAME	REASON FOR MEDICATION	DOSAGE mg(milligram)	HOW OFTEN

**MEDICATIONS: NON-PRESCRIPTION (Please include aspirin, Advil, Nuprin, Antacids, Laxatives,
Herbal products, etc.)**

NAME	REASON FOR MEDICATION	DOSAGE	HOW OFTEN

Any allergies to medication?

Medication _____ Reaction _____
 Medication _____ Reaction _____
 Medication _____ Reaction _____
 X-ray dye? _____ Reaction _____
 Novocaine? _____ Reaction _____
 Latex? _____ Reaction _____
 Eggs? _____ YES _____ NO

DOCTOR'S NOTES (Do not write in this space)