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PATIENT INFORMATION FORM

Date: _____

Last Name _____ First Name _____ Middle Name _____

DATE OF BIRTH _____ AGE_____ HEIGHT _____WEIGHT _____

PRIMARY CARE PHYSICIAN: _____REFERRING PHYSICIAN: _____

Have you ever had a colonoscopy? _____When?_____ Have you ever had a pneumonia vaccine_____If so, when?_____

Do you smoke? _____ If yes, how many packs a day? _____

REVIEW OF SYSTEMS:

Are you currently having problems with any of the following (Please circle):

CONSTITUTIONAL
Aches/Pains
Appetite Changes
Bruises easily
Fever
Chills
Hot Flashes
Fatigue
Generalized Weakness
Insomnia
Swollen Glands
Weight loss
Weight gain
Other

ALLERGIC/IMMUNOLOGIC
Seasonal
Drug
Animal
Environmental
Other

NEUROLOGIC
Stroke
Headache
Dizzy spells
Balance problems
Numbness/Tingling

NEUROLOGICAL (CONTINUED)
Tremors
Leg or Arm weakness
Memory Loss
Speech problems
Other

GASTROINTESTINAL
Acid Reflux
Indigestion/Heartburn
Nausea/Vomiting
Abdominal pain
Bloody stools
Abdominal cramps
Diarrhea
Constipation
Change bowel habits
Hemorrhoids
Gas
Rectal bleeding
Tarry stools
Other

CARDIOVASCULAR
Chest pain/angina
Edema/swelling
Hardening of arteries
Heart Attack

CARDIOVASCULAR (CONT)
Heart failure
Heart murmur
High blood pressure
Irregular heart beat
Low exercise tolerance
Mitral valve prolapse
Pain/cramps
Palpitations
Shortness of breath
Skipped heart beats
Swelling
Other

MUSCULOSKELETAL
Back Pains
Joint Pains
Neck pain/stiffness
Muscle cramps
Arthritis
Muscle weakness
Other

EAR/NOSE/THROAT
Ear infection
Sinus problems
Sore throat
Other

ENDOCRINE
Diabetes
Pituitary disease
Thyroid disease
Excess thirst
Tired/sluggish
Heat/cold intolerance
Other

RESPIRATORY
Asthma
Tuberculosis
Emphysema-bronchitis
Environmental allergies
Frequent cough
Shortness of breath
Wheezing
Other

HEMATOLOGIC/LYMPHATIC
Swollen glands
Bleeding problems
Hepatitis
HIV/(AIDS)
IV Drug use
Sickle Cell
Other

Any new surgeries in the last 18 months? _____

Any new medical problems/hospitalizations? _____

Any new medications/allergies? _____