NAME____________________________________ DATE OF BIRTH_________________TODAY'S DATE________________

PLEASE CHECK PRESENT PROBLEMS:

____NAUSEA ____GAS ____RECTAL BLEEDING

____VOMITING ____BLOATING ____ABDOMINAL PAIN

____INDIGESTION ____CHEST PAIN ____TROUBLE SWALLOWING

____ANEMIA ____UNEXPECTED WEIGHT LOSS ____BLOOD IN STOOL

____DIARRHEA ____CONSTIPATION ____MUCOS IN STOOL

PLEASE CHECK CONDITIONS THAT YOU HAVE BEEN DIAGNOSED AND TREATED FOR IN THE PAST:

____ULCERS ____HEPATITIS

____SLEEP APNEA

____HIATAL HERNIA

____SPASTIC COLON

____GALLBLADDER DISEASE

____MITRAL OR AORTIC VALVE CONDITION

____FAMILY HISTORY OF CANCER:________________________

COLON CANCER: ____YES ____NO

____FAMILY HISTORY OF GI PROBLEMS

IRRITABLE BOWEL____ GI BLEEDING____

POLYPS REMOVED____ WHAT YEAR? _________

____JOINT PROSTHESIS

PLEASE CHECK CONDITIONS THAT YOU HAVE NOW OR SURGERIES THAT YOU HAVE HAD IN THE PAST:

____DIABETES ____HIGH BLOOD PRESSURE ____TB

____HEART CONDITION ____ASTHMA ____GLAUCOMA

____SEIZURES ____HEART SURGERY

____C-SECTION ____ENDOMETRIOSIS ____HYSTERECTOMY

____STOMACH SURGERY ____COLON SURGERY ____GALLBLADDER SURGERY

____APPENDECTOMY ____RADIATION FOR PROSTATE CANCER

____OTHER – PLEASE SPECIFY ____

____

ARE YOU ON BLOOD THINNERS? ____YES ____NO IF YES, PLEASE LIST NO.__________________

ARE YOU ON STOMACH MEDICINES: ____YES ____NO

IF DIABETIC, ARE YOU ON GLUCOPHAGE? ____YES ____NO

DO YOU SMOKE? ____YES ____NO HOW MANY PACKS____ HOW LONG______

DO YOU HAVE LOOSE TEETH? ____YES ____NO ____CAPS ____BRIDGES ____DENTURES

DO YOU WEAR CONTACTS? ____YES ____NO ARE CONTACTS _____IN (or) ____OUT

WHO IS YOUR FAMILY DOCTOR? ____

PLEASE LIST YOUR PREFERRED PHARMACY _________________________________ LOCATION_________________________