PAST HISTORY

Please explain any YES answers in detailed description in the box provided.

Have you ever had any surgery or been Hospitalized? Have you had any problems with anesthesia? No ____ Yes _____ If yes, please list below:	o No o Yes	Surgeries	Dates	Hospitalizations other than surgery	Dates

Are you currently or have you ever used any Tobacco or alcohol products?	o No o Yes	Alcohol: How many drinks o per day _____ o per week _____ o per month _____ Tobacco: How many packs per day o _____ For how many years? _____
Are you or have you ever used recreational /illicit drugs?	o No o Yes	If yes, what kind? For how long?

Are you currently taking any medications or drugs (including over-the-counter, prescription, birth control pills)?	o No o Yes	Medication	Dose	Times	Medication	Dose	Times

Do you have any allergies (including environmental, medication, food, and reaction to previous blood transfusion)?	o No o Yes	
Immunization Status Have you received any of the following vaccines?		Hepatitis A _____ Date _____ Hepatitis B_____ Date _____ Pneumonia ____Date _____ Flu _____ Date Other _____

Have you ever had colon screening done?	Stool for occult cards? Yes____ No _____ Date(s)_____ Normal Abnormal	Sigmoidoscopy Yes_____ No_____ Date(s) _____ Normal Abnormal	Colonoscopy Yes____ No_____ Date(s) _____ Normal Abnormal

FAMILY HISTORY: Please indicate if your parents, brothers, sisters and/or children have had any of the following conditions:

Condition	Relation to patient	Condition	Relation to patient	Condition	Relation to patient
Colon/ Rectal Cancer No ___ Yes ___		Kidney problems No ___ Yes ___		Heart Disease No ___ Yes ___	
Stomach Cancer No ___ Yes ___		Ulcerative Colitis No ___ Yes ___		Crohn's Disease No ___ Yes ___	

_____ _____

Person Completing This Form/Relationship to Patient Reviewed by Provider Date(s)