Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PCP/Referring Dr**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies to medications**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of major surgeries (please include date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Currently* are you experiencing any of the following: (Please check yes or no)**

Change in Appetite \_\_\_\_yes \_\_\_\_no If yes, increase\_\_\_\_\_ or decrease\_\_\_\_\_\_

Difficulty Swallowing \_\_\_\_yes \_\_\_\_no If yes, liquids\_\_\_\_\_ or solids\_\_\_\_\_

Abdominal Pain \_\_\_\_yes \_\_\_\_no

Heartburn \_\_\_\_yes \_\_\_\_no

Constipation \_\_\_\_yes \_\_\_\_no

Diarrhea \_\_\_\_yes \_\_\_\_no

Change in weight \_\_\_\_yes \_\_\_\_no If yes, increase\_\_\_\_\_ or decrease\_\_\_\_\_

Rectal Bleeding \_\_\_\_yes \_\_\_\_no

Vomited Blood \_\_\_\_yes \_\_\_\_no

Black Tarry stools \_\_\_\_yes \_\_\_\_no

**Have you ever been treated for or been told you have: (Please check yes or no)**

Diabetes \_\_\_\_yes \_\_\_\_no COPD \_\_\_\_yes \_\_\_\_no

Asthma \_\_\_\_yes \_\_\_\_no Sleep Apnea \_\_\_\_yes \_\_\_\_no

High Blood Pressure \_\_\_\_yes \_\_\_\_no Heart Disease \_\_\_\_yes \_\_\_\_no

Ulcer \_\_\_\_yes \_\_\_\_no

Hepatitis \_\_\_\_yes \_\_\_\_no If yes, what type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer \_\_\_\_yes \_\_\_\_no If yes, what type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Blood Transfusion \_\_\_\_Before 1991 \_\_\_\_After 1991 \_\_\_\_never

Have you ever used illegal drugs? \_\_\_\_current \_\_\_\_former \_\_\_\_never

Do you drink? \_\_\_\_current \_\_\_\_former \_\_\_\_never

Do you smoke? \_\_\_\_current \_\_\_\_former \_\_\_\_never type of tobacco use\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

Cancer \_\_\_\_yes \_\_\_\_no If yes, who and what type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colon Cancer \_\_\_\_yes \_\_\_\_no If yes, who\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colon Polyps \_\_\_\_yes \_\_\_\_no If yes, who\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Crohn’s Disease \_\_\_\_yes \_\_\_\_no If yes, who\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Celiac Disease \_\_\_\_yes \_\_\_\_no If yes, who\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_