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PATIENT INFORMATION	
NAME:	DATE OF BIRTH:
PHONE NUMBER:	EMAIL:
OCCUPATION:	THIRD PARTY COVERAGE: Y/N

GASTROINTESTINAL SYMPTOMS		*Please leave blank for MD*
Difficulty swallowing	☐	
Heartburn	☐	
Indigestion	☐	
Nausea/Vomiting	☐	
History of ulcers	☐	
History of bleeding ulcers	☐	
Black tarry stools	☐	
Loss of appetite	☐	
Feel fuller than normal after a meal	☐	
Rectal bleeding	☐	
Recent change in bowel movements	☐	
Unexplained night time sweats	☐	
Unexplained weight loss	☐	
History of liver disease	☐	

YOUR MEDICAL HISTORY	
High blood pressure	☐
Atrial Fibrillation	☐
Heart disease – previous MI	☐
Asthma	☐
Thyroid disease	☐
Arthritis	☐
COPD/Emphysema	☐
Celiac – Diagnosed by MD	☐
Diabetes	☐
Kidney disease	☐
Genitourinary	☐
Blood Clot – lungs/legs/arms	☐

CURRENT MEDICATIONS		OVER THE COUNTER/HERBAL MEDICATIONS
1.		1.
2.		2.
3.		3.
4.		4.
5.		5.
6.		6.
7.		7.
8.		8.
9.		9.
10.		10.
11. Blood thinners?	☐	11.
12. Advil/Motrin/Aleve?	☐	12.

SURGICAL HISTORY	
1.	4.
2.	5.
3.	6.
Have you ever had a ***colonoscopy***, ***gastroscopy***, ***CT colonography***, ***barium enema*** or ***barium swallow***? If so, when?	

ALLERGIES
FOOD INTOLELRANCE

SOCIAL HISTORY		
Smoke cigarettes?	☐	*If yes, how often a day/week?*
Consume alcohol?	☐	
Smoke marijuana?	☐	
Other substance use?	☐	
Coffee	☐	*Daily intake?*
Tea	☐	
Cola	☐	
Chocolate	☐	
Peppermint	☐	
When is your last snack before bedtime?		
Average bed time?		
Number of pillows under head at night?		

Are you adopted? Y/N

FAMILY HISTORY		*Who? Age at diagnosis*
Colon cancer	☐	
Colonic polyps	☐	
Rectal cancer	☐	
Esophageal cancer	☐	
Gastric (stomach) cancer	☐	
Liver cancer	☐	
Gynecologic cancer	☐	
Inflammatory bowel disease (Crohn's/UC)	☐	
Celiac disease	☐	

Height:
Weight:
BMI: