Colonoscopy History Form

NAME: _____ DATE: _____ AGE: _____

Referring Physician: _____ Primary Care Physician: _____

Is this a (circle): ● Screening Colonoscopy ● Follow up for Polyps ● Follow up for Cancer

Are you having any:

● Abdominal pain ● Nausea ● Rectal Bleeding

● Change in Bowel Habits ● Vomiting ● Weight Loss

Previous Surgery (of any kind): _____

_____

_____

Previous Hospitalizations: _____

_____

Radiation Treatment: _____

Medical Conditions (circle): ● Heart Disease ● Diabetes ● Stroke ● Hepatitis ● Asthma
● High Blood Pressure ● HIV ● Cancer Type: _____
● Other _____

Medicines and Doses (including aspirin/laxatives): _____

_____

Allergies (please describe reactions: _____

_____

Family History: (please list which family member has a history of medical problems father, mother, sister or brother with):

● Colon rectal Cancer _____ ● Ovarian/Uterine Cancer _____

● Ulcerative Colitis _____ ● Crohn's Disease _____ ● Other _____

Social History: Occupation: _____

Tobacco: Yes ___ No ___ Alcohol: Yes ___ No ___

_____
Patient Signature