PATIENT HISTORY FORM REVIEW OF SYSTEMS

Name: _____ Date of Birth: _____

Constitutional		
Recent Weight Change	___YES	___NO
Fever	___YES	___NO
Fatigue	___YES	___NO
Eyes		
Blurred Vision	___YES	___NO
Glaucoma	___YES	___NO
Ears/Nose/Mouth/Throat		
Hearing Loss	___YES	___NO
Ringing in Ears	___YES	___NO
Mouth Sores	___YES	___NO
Cardiovascular		
Chest Pain	___YES	___NO
Shortness of Breath	___YES	___NO
Swelling of Ankles	___YES	___NO
Respiratory		
Chronic Cough	___YES	___NO
Spitting up Blood	___YES	___NO
Wheezing	___YES	___NO
Genitourinary		
Burning with Urination	___YES	___NO
Blood in Urine	___YES	___NO
Musculoskeletal		
Joint Pain	___YES	___NO
Swelling	___YES	___NO
Back Pain	___YES	___NO
Muscle Pain	___YES	___NO
Skin		
Rash	___YES	___NO
Itching	___YES	___NO

Gastrointestinal		
Poor Appetite	___YES	___NO
Difficulty in Swallowing	___YES	___NO
Heartburn	___YES	___NO
Nausea	___YES	___NO
Vomiting	___YES	___NO
Bloating	___YES	___NO
Belching	___YES	___NO
Regurgitation	___YES	___NO
Constipation	___YES	___NO
Diarrhea	___YES	___NO
Abdominal Pain	___YES	___NO
Recent Change in Bowel Habits	___YES	___NO
Rectal Bleeding	___YES	___NO
Black, Tarry Stools	___YES	___NO
Neurological		
Headaches	___YES	___NO
Seizures	___YES	___NO
Numbness	___YES	___NO
Strokes	___YES	___NO
Psychiatric		
Memory Loss or Confusion	___YES	___NO
Depression	___YES	___NO
Endocrine		
Heat Intolerance	___YES	___NO
Cold Intolerance	___YES	___NO
Excessive Thirst	___YES	___NO
Excessive Urination	___YES	___NO
Hematological		
Bleeding Tendency	___YES	___NO
Bruising Tendency	___YES	___NO
Anemia	___YES	___NO
Past Transfusion	___YES	___NO
Are you Pregnant?	___YES	___NO

Do you take any blood thinners? No ☐ Yes ☐ What Medication _____

If yes who is the prescribing doctor? _____

Medication Allergies: _____

List of Medications and Doses:

_____

_____

_____

PATIENT HISTORY FORM

Name _____ Date of Birth _____
Language: _____ Height: _____ Weight: _____ ** BMI _____ **
Primary Care Physician: _____ Pharmacy: _____ Location: _____
Reason for today's visit: _____
List all prior surgeries and date: _____
_____

Circle Present and Past Medical History:
Hypertension Heart Attack Angina Arrhythmia Congestive Heart Failure Heart Murmur Elevated Cholesterol Diabetes Anemia Arthritis Blood Clot in Leg or Lung Seizure Stroke Hepatitis Tuberculosis Cancer Asthma Bronchitis Emphysema Rheumatic Fever Thyroid Disease Peptic Ulcer Hiatal Hernia Ulcerative Colitis Crohn's Disease Irritable Bowel Syndrome Sleep Apnea Anxiety/Depression Reflux Constipation
Other: _____

Have you ever had a colonoscopy before?
☐ No ☐ Yes
If so, when and where? _____

Have you ever had any problems with anesthesia or sedation? ☐ No ☐ Yes
If yes, what happened? _____

Have you ever smoked? ☐ No ☐ Yes
If currently smoking, how many packs per day? _____
If not currently smoking, quit date: _____
Do you drink alcohol? ☐None ☐Occasional ☐Daily
Recreational drug use? ☐ No ☐ Yes
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed
Do you work? ☐ No ☐ Yes Type of Work: _____

Any family history of liver disease, celiac disease, Crohn's, ulcerative colitis, other cancer? _____
Colon Polyps: ☐ No ☐ Yes Whom: _____
Colon Cancer: ☐ No ☐ Yes Whom: _____
Other Significant Disease(s): _____

To Be Completed by Gastroenterologist on day of exam:

HPI: _____
_____
_____
_____
_____
_____

Physical Examination: BP_____ Hgt_____Wgt_____	**Yes**	**No**	**Comments**
1. Constitutional: Well-nourished/well developed:	☐	☐	_____
2. Skin: Skin free of rashes, purpura, petechiae, stigmata:	☐	☐	_____
3. Eyes: Lids and Conjunctivae normal:	☐	☐	_____
4. Ears/Nose/Mouth/Throat: Is the oral mucosa pink/moist	☐	☐	_____
5. Hematologic/Lymphatic/Immunologic: Nodes in neck nl:	☐	☐	_____
6. Respiratory: Lungs clear to auscultation:	☐	☐	_____
7. Cardiovascular: Heart rate regular & no murmur:	☐	☐	_____
8. Gastrointestinal: Soft, nl tympany, active bs, no hsm no masses, no tenderness	☐	☐	_____
9. Musculoskeletal: No clubbing, deformities, edema of extremities	☐	☐	_____
10. Rectal: Hem occult negative:	☐	☐	_____
11. Neurologic: Intact	☐	☐	_____
12. Psychiatric: Alert, oriented to time/person/place	☐	☐	_____

Reviewed By _____ Date: _____
ASA: _____
I have reassessed the patient and find no changes to the above
Reviewed By: _____ Date: _____

WEYMOUTH ENDOSCOPY, LLC