

Health History Form (1/3)

Reason for visit:
Medical history: please check "✓" or type "Y" in the space if you have ever had the following:

Anemia	<input type="checkbox"/>	Diverticular disease	<input type="checkbox"/>	Polyps of colon or rectum	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Prostate problem*	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Gastroesophageal reflux	<input type="checkbox"/>	Psychiatric disorder*	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Cancer of colon or rectum	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>
Cancer of other type*	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	Skin disorder	<input type="checkbox"/>
Chest pain / Angina	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Sleep apnea	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	Hernia*	<input type="checkbox"/>	Spinal disease*	<input type="checkbox"/>
Clotting disorder	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Congestive heart failure (CHF)	<input type="checkbox"/>	High lipid / cholesterol	<input type="checkbox"/>	Substance abuse	<input type="checkbox"/>
COPD	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Thyroid disease*	<input type="checkbox"/>
Crohn's disease	<input type="checkbox"/>	Irregular heart rate*	<input type="checkbox"/>	Tuberculosis (TB)	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	Ulcerative colitis	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Liver disease*	<input type="checkbox"/>	Ulcer of stomach/ duodenum	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Neuromuscular disease	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>

Other:

*Please specify/elaborate:

Any previous colonoscopy: No Yes: date:

If female patient, any childbirth: No Yes: Vaginal delivery age/yr C-section age/yr

Any prolonged labor, tear or episiotomy during vaginal delivery, forcep or vacuum-assisted delivery? No Yes

If you had anesthesia for procedures in the past, any problem with anesthesia? No Yes:
Previous Surgery: please list any surgeries you have had and the date

Surgery	Date

Health History Form (2/3)

Height: Weight: Primary care doctor:

Pharmacy name: Location: Phone:

Medications: Do you take any medications or supplements regularly? < Skip if you updated this info during online self check-in >

No Yes → please list below or bring your list to visit

Name of medication (prescription or over the counter) / supplement	Dosage	Frequency
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Allergies to any medication, food, latex or other substance? No Yes → please list and explain below

Medication / substance you are allergic to:	Reaction:
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Family history: please list any known medical problems (or cause of death if deceased) in your family members

Mother:

Father:

Brother:

Sister:

Maternal grandparent:

Paternal grandparent:

Children:

Uncles/Aunts/Cousins:

Social history:

Tobacco use: Never Previous use, quit Current smoker → Type & frequency:

Alcohol use: No Yes → Type and frequency:

Recreational drug use: No Yes → Type: cannabis heroin cocaine other:

Sexual activity: Sexually active? No Yes Sexual partner? M F Both

Health History Form (3/3)

Today's date:

Please check "✓" or type "Y" in the space if you have the following recently:

Constitutional

Fever
 Chills
 Increased sweating
 Weakness or fatigue
 Unexpected weight loss
 Appetite change

Eye

Eye pain
 Discharge
 Yellow discoloration
 Light sensitivity
 Visual disturbances

Ear, Nose, Mouth, Throat

Decreased hearing
 Ear pain
 Nasal congestion
 Sore throat
 Dental problem

Respiratory

Frequent cough
 Shortness of breath
 Wheezing

Cardiovascular

Chest pain
 Palpitation
 Arrhythmia
 Hand or feet swelling

Gastrointestinal

Abdominal pain
 Anal or rectal pain
 Blood in stool / on paper
 Change in bowel habit
 Constipation
 Diarrhea
 Fecal incontinence
 Bloating / distention
 Nausea
 Vomiting
 Heartburn / reflux
 Difficulty swallowing

Genitourinary

Painful urination
 Blood in urine
 Frequent urination
 Change in urine stream
 Urine retention / incontinence
 Abnormal lesion / growth
 Penile / vaginal discharge
 Sexual dysfunction

Endocrine

Heat or cold intolerance
 Excessive thirst
 Excessive hunger

Hematology/Lymphatic

Bruise/bleed easily
 Swollen lymph gland

Musculoskeletal

Muscle ache / pain
 Joint pain / swelling
 Stiffness
 Decreased range of motion

Skin

Rash
 Itch
 Hair / nail change
 Abnormal / new growth

Neurological

Frequent headache
 Dizziness / fainting
 Tremors
 Numbness
 Balance/coordination problem

Psychiatric

Anxiety
 Depression
 Increased stress
 Sleep problem
 Memory loss
 Suicidal ideation

Immunologic

Recurrent infection
 Environmental or food allergy
 Immunocompromised