Name:_____ **Referring doctor:**_____
Date of Birth _____ **Gender**_____ **Allergies:**_____

Marital status: M S W D

Check the following if apply:

Current and past medical conditions
___HEART DISEASE
___HYPERTENSION
___DIABETES
___SLEEP APNEA
___ARTHERITIS
___BLEEDING DISORDER
___SKIN DISEASE
___LIVER DISEASE
OTHER:_____

Previous Sugeries
____GALLBLADDER
____APPENDIX
____HYSTERECTOMY
___PROSTATE SURGERY
OTHERS:_____
_____
_____

Current Medications:
1_____ **2**_____ **3**_____ **4**_____
5_____ **6**_____ **7**_____ **8**_____
9_____ **10**_____ **11**_____ **12**_____

Is there family history of the following: Colon cancer, colon polyp, colitis, hepatitis, liver cancer, liver diseases, stomach cancer, small intestinal cancer, pancreatic cancer? If yes please indicate the relation and the age of onset.

_____
_____
_____

Females Only: Number of children____Number of Pregnancies____
Date of Last Cycle_____ Is there a possibility that you may be pregnant? **Y N**

Check if you have the following:
_____Chest pain, palpitation _____shortness of breath, ___wheezing, ____headache, _____numbness, ____weakness, _____ dizziness, _____visual problems, ____skin rash, _____jaundice, _____fever, ____unexpected weight loss, _____ pain on urination, _____ difficulty urinating,

Briefly describe your symptoms including time of onset, location, and frequency

_____
_____
_____
_____