PATIENT UPDATE FORM

NAME: _____ **DATE OF BIRTH:** _____ **ACCOUNT#:** _____
EMERGENCY CONATCT _____ **EMERGENCY #**_____
Reason for today's visit: _____

Do you have or have you had any of the following:

Diabetes: _____ Stroke: ____ Seizure Disorder: _____ Hepatitis: _____
Heart Attack: _____ Heart Disease: _____ Mitral Valve Prolapse: _____ Anemia: _____
High Blood Pressure: _____ Sleep Apnea: _____ High Cholesterol: _____ Asthma: _____
Pacemaker: _____ Defibrillator: _____ Thyroid Disease: _____ COPD: _____
Heart Murmur: _____ Heart Valve Disease: _____ Joint Replacement: _____ Liver Disease: ____
Kidney Disease: _____
Other medical/psychiatric conditions: _____

Past Surgical History (list ALL surgeries and the dates):
_____
_____

Are you under the care of any physicians/specialist other than your primary physician? Yes___ No ___
If yes, list name and specialty: _____
_____
Do you require information to be released to above physicians? Yes___ No ___

Is there a family history of colon polyps, colon cancer or any other cancers? Yes___ No ___
If yes, what type and who? _____

Do you smoke? Yes___ No___ If yes, how long? _____
Do you drink alcohol? No___ Occasionally___ Regularly___
Do you have a history of previous drug abuse? Yes___ No___

Please list ALL prescription medications taken including over the counter products and the dosing instructions:
_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you have any allergies to any medications? Yes___ No___
Name of Medications: _____
Type of Reaction: _____

Do you have an advanced directive in place? _____Yes _____No
If yes, do you have: ___Living Will ___Power of Attorney ___Healthcare Proxy ___DNR
Please be advised, if you do have any advanced directive, our office is required to obtain a copy for your records.

Gastro-Intestinal: Have you ever experienced any of the following?

Vomiting Blood___ Diarrhea___ Change in bowel habits___ Black stools___
Rectal bleeding___ Constipation___ Difficulty swallowing___ Weight loss___

*Have you had a previous colonoscopy/endoscopy? Yes___ No___

When: _____ Where: _____