Name:_____ **Age:**_____ **Date:**_____

Occupation:_____ **Referring MD:**_____

Have you been having any of the following symptoms?					
YES	**NO**		**YES**	**NO**	
☐	☐	Poor appetite	☐	☐	Heart Attack
☐	☐	Weight Loss	☐	☐	Endocarditis/ Infected Heart Valve
☐	☐	Weight Gain	☐	☐	Defibrillator Placement
☐	☐	Fevers, Chills or Sweats	☐	☐	Heart Valve Replacement
☐	☐	Difficulty Swallowing	☐	☐	Mitral Valve Prolapse
☐	☐	Painful Swallowing	☐	☐	Palpitations/ Irregular Heart Beat
☐	☐	Heartburn/ Indigestion	☐	☐	Pain in Calves when Walking
☐	☐	Regurgitation of liquid/ food	☐	☐	Weakness/ Numbness
☐	☐	History of Ulcers	☐	☐	Blacking out Spells
☐	☐	Recurrent Vomiting	☐	☐	Seizures
☐	☐	Abdominal Pain	☐	☐	Chest Pain/ Tightness
☐	☐	Constipation	☐	☐	Shortness of Breath
☐	☐	Diarrhea	☐	☐	History of Sleep Apnea
☐	☐	Blood in Stool	☐	☐	Blood in Urine
☐	☐	Hemorrhoids	☐	☐	Painful Urination
☐	☐	Rectal Pain	☐	☐	History of Kidney Problems
☐	☐	Jaundice	☐	☐	Arthritis/ Joint Pain
☐	☐	Excessive Bleeding	☐	☐	Recurrent Skin Rash
☐	☐	History of Blood Transfusion	☐	☐	Panic Attacks/ Anxiety
☐	☐	Anemia	☐	☐	Depression
☐	☐	Easy Bruising	☐	☐	History of Thyroid Disease
☐	☐	Stent or Graft placement	☐	☐	Hair Loss

Please list any past/ present medical problems & date (diabetes, high blood pressure, heart attack, etc.)			
Date	Medical Problem	Date	Medical Problem

Please list any operations or hospitalizations & approximate year			
Year	Operation/ Hospitalization	Year	Operation/ Hospitalization

Do you or have you ever:			
Smoked?	☐ Yes	☐ No	Packs per day _____/ years smoking _____
Used Snuff, Chew, Pipes, Cigars?	☐ Yes	☐ No	
Drink Alcohol?	☐ Yes	☐ No	What type and how much/week?

Marital Status?:	☐ Single	☐ Married	☐ Divorced	☐ Widowed
Children?	Number _____ Ages _____ Last Menstrual Period _____			

Has anyone in your family had:						
☐	Colon Polyps	☐	Uterine Cancer	☐	High Blood Pressure	☐ Other ___
☐	Colon Cancer	☐	Bladder Cancer	☐	Heart Attack	_____
☐	Ulcerative Colitis	☐	Stomach Cancer	☐	Stroke	_____
☐	Crohn's Disease	☐	Ulcers	☐	Pancreatitis	_____
☐	Breast Cancer	☐	Diabetes	☐	Anemia	_____
☐	Liver Disease	☐	Bleeding Disorder	☐	Hemochromatosis	_____
☐	Ovarian Cancer	☐	Heart Disease	☐	Celiac Sprue	