

**PLEASE USE BLACK INK**

**CHANGES TO MEDICAL HISTORY FORM**

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**\* Please review your medical history form, and describe any changes, which have occurred since you first filled out this form. Please sign and date this page. This will help your physician stay up to date on changes to your health history since your last visit to our office.**

**SURGERIES** \_\_\_\_\_

**ILLNESSES** \_\_\_\_\_

**ALLERGIES** \_\_\_\_\_

**CHANGE IN HABITS (i. e. smoking, alcohol etc.)** \_\_\_\_\_

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**If you are 50 years of age or older have you recently had a flexible sigmoidoscopy performed?** YES  
NO

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
PRINT PLEASE

\_\_\_\_\_  
**Patient Account number**

\_\_\_\_\_  
**Patient signature**

\_\_\_\_\_  
**Physician initials**

\_\_\_\_\_  
**Date**

**\*\*PLEASE COMPLETE BACK SIDE OF THIS FORM\*\***

## PLEASE ANSWER ALL QUESTIONS

### HAVE YOU HAD ANY OF THE FOLLOWING DURING THE PAST ONE YEAR?

<p><b>CONSTITUTIONAL</b></p> <p>No problem</p> <p>Fever..... No    Yes</p> <p>Fatigue..... No    Yes</p> <p>Headaches..... No    Yes</p> <p><b>EYES</b></p> <p>No problem</p> <p>Eye disease..... No    Yes</p> <p>Wear glasses/contacts..... No    Yes</p> <p>Blurred or double vision..... No    Yes</p> <p><b>ENT</b></p> <p>No problem</p> <p>Loss of voice/laryngitis..... No    Yes</p> <p>Hearing loss..... No    Yes</p> <p>Mouth sores..... No    Yes</p> <p>Bleeding gums..... No    Yes</p> <p><b>CARDIOVASCULAR</b></p> <p>No problem</p> <p>Heart trouble..... No    Yes</p> <p>Chest pains..... No    Yes</p> <p>Swelling of feet or ankles..... No    Yes</p> <p>History of blood clots (DVT)..... No    Yes</p> <p>Heart murmur..... No    Yes</p> <p><b>RESPIRATORY</b></p> <p>No problem</p> <p>Frequent coughing..... No    Yes</p> <p>Shortness of breath..... No    Yes</p> <p>Asthma or wheezing..... No    Yes</p> <p><b>GENITOURINARY</b></p> <p>No problem</p> <p>Frequent urination..... No    Yes</p> <p>Burning or painful urination..... No    Yes</p> <p>Blood in urine..... No    Yes</p> <p>Kidney stones..... No    Yes</p> <p>Male</p> <p>-prostate problems..... No    Yes</p> <p>Female</p> <p>- heavy/ irregular periods... No    Yes</p> <p>- endometriosis..... No    Yes</p> <p>History of sexual abuse..... No    Yes</p> <p>Anal intercourse..... No    Yes</p>	<p><b>MUSCULOSKELETAL</b></p> <p>No problem</p> <p>Joint stiffness or swelling..... No    Yes</p> <p>Muscle pain or cramps..... No    Yes</p> <p>Back pain..... No    Yes</p> <p><b>SKIN</b></p> <p>No problem</p> <p>Rash or itching..... No    Yes</p> <p>Change in moles or skin lesions..... No    Yes</p> <p>Tattoos..... No    Yes</p> <p><b>NEUROLOGICAL</b></p> <p>No problem</p> <p>Head injury..... No    Yes</p> <p>Convulsions or seizures..... No    Yes</p> <p>Numbness or tingling sensations..... No    Yes</p> <p>Tremors..... No    Yes</p> <p>Paralysis..... No    Yes</p> <p>Stroke..... No    Yes</p> <p><b>PSYCHIATRIC</b></p> <p>No problem</p> <p>Memory loss or confusion..... No    Yes</p> <p>Nervousness..... No    Yes</p> <p>Depression..... No    Yes</p> <p>Suicide attempt..... No    Yes</p> <p>History of sexual abuse..... No    Yes</p> <p><b>ENDOCRINE</b></p> <p>No problem</p> <p>Thyroid disease..... No    Yes</p> <p>Diabetes..... No    Yes</p> <p><b>HEMATOLOGIC/LYMPHATIC</b></p> <p>No problem</p> <p>Easily bruise or bleed..... No    Yes</p> <p>Anemia..... No    Yes</p> <p>Phlebitis..... No    Yes</p> <p>Enlarged glands..... No    Yes</p> <p>HIV +/-AIDS..... No    Yes</p>
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**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**PRINT PLEASE**

PATIENT SIGNATURE \_\_\_\_\_ PHYSICIAN SIGNATURE \_\_\_\_\_

**\*\*PLEASE GO ON TO NEXT PAGE\*\***