Patient Information

Email
Please check one as your preferred email for communications

☐ Personal: _____ ☐ Work: _____

Race
Select one or more

☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Other Race ☐ Unknown ☐ Patient declines to specify ☐ Prohibited by state law

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify ☐ Prohibited by state law ☐ Unknown

Contact Preference

☐ Letter ☐ Email ☐ No Preference ☐ Patient declines to specify Other: _____

Preferred Language

☐ English ☐ Patient declines to specify

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies

Food ☐ Peanuts ☐ Shellfish ☐ Eggs ☐ Soy ☐ Dairy
Other: _____

Medications ☐ Sulfa (Sulfonamide Antibiotics) ☐ Penicillins Other: _____

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

☐ Yes ☐ No

Current Medications

☐ None

Name	Dose	How taken?

Past or Present Medical Conditions

- [ ] None

- [ ] Acid Reflux
- [ ] Anxiety disorder
- [ ] Asthma
- [ ] Atrial Fibrillation
- [ ] Barrets Esophagus
- [ ] Hemophilia
- [ ] Ulcerative Colitis
- [ ] Colon polyps
- [ ] C.O.P.D.
- [ ] Crohn's Disease
- [ ] Depression
- [ ] Diabetes Mellitus
- [ ] Diverticulitis
- [ ] Elevated cholesterol
- [ ] Emphysema
- [ ] Glaucoma
- [ ] Heart Disease
- [ ] History of Hepatitis B
- [ ] High blood pressure
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mitral Valve Prolapse/MR
- [ ] Hepatitis C
- [ ] Pacemaker
- [ ] Problems with Anesthesia: Please specify: _____
- [ ] Seizures
- [ ] Stroke
- [ ] Thyroid disorder
- [ ] Tuberculosis
- [ ] Cancer: Please Specify type: _____
- [ ] Ischemic Vascular Disease (IVD)
- [ ] Human immunodeficiency virus infection (HIV)
- [ ] Dementia
- [ ] Alzheimer
- [ ] Parkinsons
- [ ] End-stage renal disease
- [ ] History of falling
- [ ] Dependence on wheelchair
- [ ] Dependence on supplemental oxygen
- [ ] Hospice care patient
- [ ] Palliative care patient
- [ ] Nursing home resident

Previous Procedures

- [ ] None

- [ ] Appendectomy — When:_____
- [ ] Back Surgery — When:_____
- [ ] Bladder Surgery — When:_____
- [ ] Cataract surgery — When:_____
- [ ] Colon Resection — When:_____
- [ ] D and C — When:_____
- [ ] Gallbladder removed — When:_____
- [ ] Hernia Repair — When:_____
- [ ] Hysterectomy — When:_____
- [ ] Liver Biopsy — When:_____
- [ ] Mastectomy Breast: Right/Left/Both — When:_____
- [ ] Open Heart Surgery- — When:_____
- [ ] Prostate — When:_____
- [ ] Tonsillectomy — When:_____
- [ ] Tubal Ligation — When:_____
- [ ] Wisdom Teeth Removed — When:_____
- [ ] Other surgeries not listed: — When:_____ Other:_____

Diagnostic Studies/Tests

- [ ] None

- [ ] Colonoscopy — When:_____
- [ ] EGD — When:_____
- [ ] Flexible fiberoptic sigmoidoscopy — When:_____
- [ ] Fecal Occult Stool Test — When:_____

Immunizations

- [ ] None

- [ ] Pneumonia — When:_____
- [ ] Flu Shot — When:_____
- [ ] COVID VACCINE — When:_____

Social History

Occupation:_____ Number of Children:_____

Marital Status

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Separated
- [ ] Widowed
- [ ] Civil Union
- [ ] Unknown
- [ ] Other

Caffeine

- [ ] None
- [ ] Yes — Intake:_____

Alcohol

☐ None

Type	Quantity	Number	Frequency
☐ beer			
☐ liquor			
☐ wine			

Exercise

☐ None

Type	Number
☐ Yes	

Tobacco

Smoking Status

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker

☐ Smoker, current status unknown ☐ Light tobacco smoker ☐ Heavy tobacco smoker ☐ Unknown if ever smoked

Type	Quit	Quantity	Frequency
☐ Chewing Tobacco			

Drug Use

☐ None

Type	Number
☐ marijuana	
☐ other illicit drugs	

Family Medical History

☐ No knowledge of family history

No family history of ☐ Colon Cancer ☐ Colon Polyps

	Mother	Father	Sister	Brother	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather
Health Status								
Age/Date of Birth								
Alive	○	○	○	○	○	○	○	○
Deceased/At Age	○	○	○	○	○	○	○	○
Cause of Death								
Diagnoses								
History of Cancer: type_____	○	○	○	○	○	○	○	○
History of Heart Disease (heart attack, heart failure)	○	○	○	○	○	○	○	○
History of Colon Cancer	○	○	○	○	○	○	○	○
History of Strokes	○	○	○	○	○	○	○	○

History of Diabetes	○	○	○	○	○	○	○	○
History of High Blood Pressure	○	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○	○

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

☐ Yes ☐ No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

☐ Yes ☐ No

Reviewed with (Internal Use Only, not shown in Portal)

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present