MID-VALLEY
GASTROENTEROLOGY
Specialists in Digestive Health

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Your safety and health are our first priority. In order to provide responsive, efficient, and customized care, please complete each section to the best of your ability. If you need more space, please attach a separate page.

Name: _____ DOB: _____ Height: _____ Weight: _____
Primary Care Provider: _____ Referred by: _____
Pharmacy name & location: _____ Advanced directive? Yes or No
Insurance name: _____ Subscriber ID: _____ Subscriber name: _____

PERSONAL MEDICAL HISTORY:

Cigarette Smoking:	Yes ☐ No ☐	# packs per day _____	Number of years _____
Smokeless Tobacco:	Yes ☐ No ☐	How much/often _____	Number of years _____
Quit Nicotine Use:	Yes ☐ No ☐	When _____	
Alcohol Use:	Yes ☐ No ☐	How much/often _____	Number of years _____
Quite Alcohol Use:	Yes ☐ No ☐	When _____	
Drug Use:	Yes ☐ No ☐	Type _____	How much/often _____
Marijuana Use:	Yes ☐ No ☐	How much/often _____	

MEDICATIONS: Please list all current medications, dosages and schedule (include prescriptions & supplements):
_____
_____
_____
_____
_____
_____
_____
ALLERGIES: Please list any medication allergies, intolerances, and reactions: _____
_____
_____
_____

Please circle YES or NO for the following questions:
Are you able to participate in moderate exercise? For example, can you climb a flight of stairs carrying a bag of groceries without stopping, walk up a hill, perform heavy house or yard work, go dancing, golfing, or bowling? YES or NO

If no, please explain: _____

Do you have any new or unstable cardiac symptoms or have you had any heart related procedures in the last 12 months? This would include symptoms such as chest pain, heart palpitations, shortness of breath, heart failure, coronary artery disease, or a heart attack. YES or NO

If yes, please explain your symptoms and/or recent cardiac procedures: _____
_____

Do you have a pacemaker? YES or NO

Do you have a defibrillator? YES or NO

Do you have a heart stent? YES or NO

If yes, date of stent placements: _____

Have you had heart surgery? YES or NO

Are you on dialysis? YES or NO

Do you take any prescription blood thinners? *Expamples: Coumadin, Plavix, Eliquis, Xarelto* YES or NO

Do you currently have any of the following symptoms lasting longer than 3 weeks? Please check the boxes that apply:

- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Crohn's disease
- ☐ Constipation
- ☐ Black stool
- ☐ Ulcerative colitis
- ☐ Cirrhosis
- ☐ Abdominal pain
- ☐ IBS
- ☐ Colon cancer
- ☐ None

Have you had a previous colonoscopy? YES or NO

If yes, please include the year and if any polyps were found and what type of polyp: _____

_____

_____

Have you had seizures? YES or NO

If yes, date of last seizure: _____

Do you currently have MRSA? YES or NO

Do you have any other health conditions? _____

_____

_____

_____

Do you have any of the following mental health diagnosis? Please check all boxes that apply:

- ☐ Severe anxiety
- ☐ Depression
- ☐ Other
- ☐ PTSD
- ☐ Mild or moderate anxiety
- ☐ None
- ☐ Bipolar disorder
- ☐ History of abuse (physical or sexual)

Do you have any of the following sleep devices? Please check all boxes that apply:

☐ CPAP ☐ BiPAP ☐ Oxygen ☐ None

Do any of the following apply? Please check the "None" box if non of the below apply:

- ☐ History of excessive bleeding during dental or surgical procedures
- ☐ COPD
- ☐ Heart failure
- ☐ Chronic kidney disease
- ☐ Prior complications from anesthesia besides post-operative nausea/vomiting
- ☐ Home oxygen use
- ☐ Atrial fibrillation
- ☐ Loose or broken teeth
- ☐ Coronary artery disease
- ☐ Diabetes
- ☐ None

Have any of your blood relatives been diagnosed with any of the following? Please check all that apply:

- ☐ Ulcerative colitis
- ☐ Crohn's disease
- ☐ Liver disease
- ☐ Stomach cancer
- ☐ Rectal or colon polyps
- ☐ Unknown family history
- ☐ Rectal or colon cancer
- ☐ Celiac disease
- ☐ None

Please list the blood relative(s) relationship to you, their diagnosis and their age at the time of diagnosis:

_____
_____
_____

Have any of your blood relatives been diagnosed with cancer? YES or NO

If yes please list the blood relative(s) who were diagnosed with cancer, their relationship to you, type of cancer and their age at the time of diagnosis:

_____
_____
_____