PERSONAL INFORMATION SHEET

NAME ON CARE CARD: CARE CARD #:

PHONE #: EMERGENCY CONTACT NAME AND #:

DATE OF BIRTH: (mm/dd/yyyy) OCCUPATION:

PAST MEDICAL HISTORY (Check all conditions you have had and now have):

_____Heart attack	_____Diabetes	_____Asthma
_____Angina	_____Blood clotting issues	_____Lung disease
_____Heart murmur	_____Thyroid disease	_____Kidney disease
_____Fast/irregular heartbeat	_____High cholesterol	_____Seizures
_____High blood pressure	_____Hepatitis	_____Migraines
_____Stroke	_____Liver problems (List below)	_____Glaucoma
_____Rheumatic fever	_____Anxiety	_____Chronic pain
_____Drug/Alcohol addiction	_____Depression	_____Fibromyalgia

List any other medical problems:

When and where was your last colonoscopy? ________________________ _____Never had one

PAST SURGICAL HISTORY (Please list):

SURGERY	HOSPITAL	DATE

Have you or a family member ever had problems with anesthetic? If so, describe:

FAMILY HISTORY (Check all that apply):

_____Colon or rectal cancer Affected relative(s):
_____Inflammatory bowel disease Affected relative(s):
(e.g., Crohn's or Ulcerative Colitis)

MEDICATIONS (List all you are taking now, including over-the-counter medications):

ALLERGIES (List substance and reaction):

Do you have a Latex allergy? (Please circle) YES NO

SOCIAL HISTORY:

TOBACCO: _____NO _____YES Year Quit:______ Year Started:______ # per day:____
ALCOHOL: _____NO _____YES How many drinks, how often? ___________________________
DRUGS: _____NO _____YES