**EDMUND KRASINSKI, JR., D.O., F.A.C.G., P.L.L.C.**

| ***LAST NAME*** | ***FIRST NAME*** | ***D.O.B.*** | ***TODAY'S DATE*** |
|---|---|---|---|

**Who is your primary doctor?** ______________________________________________

**Who referred you for this appointment?** ______________________________________

**Reason for visit:** ___________________________________________________

**Do you currently have or have you had history of the following:**

_______ Pancreatitis
_______ Ulcerative Colitis
_______ Crohn's Colitis
_______ Colon Cancer / Polyps (please circle which one)
_______ Barrett's Esophagus
_______ Ulcers (stomach or esophageal)
_______ Liver problems / Hepatitis
_______ Diverticulosis / Diverticulitis
_______ Family History of Colon Cancer: if yes, which family member: ___________ what age: ________
_______ Family History of Colon Polylps: if yes, which family member: ___________ what age: ________

**Have you previously had any of the following tests:**

_______ Colonoscopy Where and When: ____________________________________

_______ Sigmoidoscopy Where and When: ____________________________________

_______ Endoscopy (EGD) Where and When: ____________________________________

_______ Upper GI/ Small Bowel Series Where and When: ____________________________________

_______ MRI Where and When: ____________________________________

Body Part: ____________________________________

_______ CT/CAT Scan Where and When: ____________________________________

Body Part: ____________________________________

_______ Barium Enema Where and When: ____________________________________


Please cont. on to next page

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______________________________________________________________________

***LAST NAME*** ***FIRST NAME*** ***D.O.B.*** ***TODAY'S DATE***

**EYES**
_______ Vision Changes
_______ Cataracts
_______ Glaucoma

**EAR/NOSE/THROAT**
_______ Ear Aches
_______ Decreased hearing
_______ Frequent nose bleeds
_______ Cold symptoms
_______ Sore throat
_______ Swollen glands

**RESPIRATORY**
_______ Cough
_______ Phlegm production
_______ Wheezing
_______ Shortness of breath
_______ Pain with breathing

**GENITOURINARY**
_______ Painful urination
_______Frequent urination
_______ Blood in urine
_______ Frequent infections
_______ Urine incontinence
_______ Kidney pain

**GYNECOLOGIC/OBSTETRIC**
_______ Irregular periods
_______ Ovarian Cysts
Are you/or could you be pregnant?
Yes: ________ No: __________

**MUSCULOSKELETAL**
_______ Joint pain or swelling
_______ Arm/leg weaknes
_______ Arm/leg numbness

**SKIN**
_______ Rash
_______ Skin Ulcer

**NEUROLOGICAL**
_______ Significant headaches
_______ Confusion
_______ Dizziness
_______ Balance problems

**PSYCHIATRIC**
_______ Mental health problems
_______ Major Depression

**ENDOCRINE**
_______ Thyroid problems
_______ Voice change

**HEMATOLOGIC**
_______ Abnormal bleeding

**Have you been recently hospitalized?** ____________________
**Reason:** ________________________________________
________________________________________________________

**Past Operations:** ________________________________________
________________________________________________________
________________________________________________________

**Family History:**
Fathers Health: ________________________________________
Mothers Health: ________________________________________
Siblings Health: ________________________________________

**Social History:** Occupation ______________________________
Smoke _______ If yes, how much: __________________________
Alcohol _______ If yes, how much: __________________________

**PAST MEDICALHISTORY**
_______ Diabetes
_______ Cancer: Type_____
_______ Stroke
_______ Emphysema
_______ Arthritis
_______ AIDS/HIV
_______ Kidney Stones
_______ Hepatitis
_______ Venereal Disease
_______ Pneumonia

**CARDIAC**
_______ Chest Pain
_______ Irregular Heartbeat
_______ Heart Attack
_______ Hypertension

***Patient Signature:*** ________________________________________________________

***Date:*** ______________________________