DIGESTIVE HEALTH ASSOCIATES of Cheyenne
7212 Commons Circle
Cheyenne, WY 82009

Phone: 307-635-4141
Fax: 307-638-2656
www.dhawy.com

Wyoming Endoscopy Center
7220 Commons Circle
Cheyenne, WY 82009

Review of Systems / Past Medical History

Patient Name_____

Date of Birth_____

Please mark the conditions that apply:

General:

___Chronic Fatigue
___Bruise Easily
___Fever
___Less Interest on doing things
___Thyroid Disease
___Anemia
___Weight Loss (amount___)
___Cancer_____
___Weight Gain (amount___)
___Diabetes (diagnosed when_____)

Eyes, Ears, Nose & Throat:

___Ringing in Ears
___Sinus Trouble
___Poor Vision
___Ear Infections
___Hoarseness
___Glaucoma
___Dizzy Spells
___Eye Infections
___Cataracts

Lungs:

___Pneumonia
___Bronchitis
___Shortness of Breath
___Asthma
___Cough

Heart:

___Chest Pain
___Palpitations
___Irregular Heart Beat
___High Blood Pressure
___Ankle Swelling
___Blood Clots

Skin:

___Rashes
___Allergic Reaction/Hives
___Growths

Urinary:

___Urinary Infections
___Painful Urination
___Blood In Urine
___Kidney Stones
___Urination at Night
___Decrease in Urine Force or Flow

Bones and Joints:

___Arthritis
___Weak Bones
___Back Pain
___Swollen Joints

Neurological/Psychiatric:

___Stroke
___Depression
___Seizures
___Tremors/Hands Shaking
___Nervousness
___Panic Attacks
___Numbness or Tingling
____Problems Sleeping
___Migraines
___Headaches (frequent)
___Memory Loss
___Anxiety

Gastrointestinal:

___Diarrhea
___Constipation
___Liver Disease
___Heartburn
___Stomach Pain
___Gas
___Black Stools
___Poor Appetite
___Trouble Swallowing
___Nausea
___Vomiting
___Change In Bowels
___Blood In Stool
____Bloating

Additional information you feel is important:_____

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Medication / Allergy Review and Family History

Patient Name_____

Date of Birth_____

Medications: (please list if not attached)

Medication Name:	Dose	Frequency

Allergies: (please list if not attached)

Name of Allergen	Reaction

Family History of colon cancer, please list maternal or paternal blood relative if applicable:

		If yes, Whom	Age of onset
History Colon Cancer	YES / NO		
History Colon Polyps	YES / NO		

Other GI Surgical procedures not listed:_____

_____

_____

Please list any lab or radiological testing performed within the last year and where:_____

_____

_____