PAST MEDICAL HISTORY:

Please circle either Yes or No:

Colon Cancer	Yes	No
Colon Polyps	Yes	No
Ovarian Cancer	Yes	No
Uterine Cancer	Yes	No
Heart Attack/Myocardial Infarction	Yes	No
High Cholesterol/Hyperlipidemia	Yes	No
Angioplasty/Coronary Stent	Yes	No
Pacemaker/Defibrillator	Yes	No
Heart Murmur	Yes	No
Irregular Pulse/Atrial Fibrillation	Yes	No
Stroke/CVA/TIA	Yes	No
COPD/Emphysema	Yes	No
Sleep Apnea	Yes	No
Kidney disease or failure	Yes	No
Liver disease	Yes	No
Diabetes	Yes	No

CURRENT GASTROINTESTINAL ILLNESSES:

Please circle if you are currently experiencing the following symptoms:

Abdominal Pain	Yes	No
Unintentional weight loss	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Rectal Bleeding	Yes	No

Height:______________________ Weight: ___________________

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Patient Signature Date