

**ROBERT E. DAVIS, M.D., F.A.C.P., F.A.C.G., A.G.A.F**

**Name (s) and address of physicians with previous medical records:**

\_\_\_\_\_

\_\_\_\_\_

**Previous hospitalization:** (Place, Date, Reason)

\_\_\_\_\_

\_\_\_\_\_

**All previously diagnosed medical and / or surgical illness, including childhood:**

\_\_\_\_\_

**FAMILY HISTORY:** (Parents, uncles, aunts, siblings, children, grandparents on both sides- be specific)

Diabetes Mellitus \_\_\_\_\_

Gallbladder (stones, etc.) \_\_\_\_\_

Heart Disease \_\_\_\_\_

High Blood Pressure (Hypertension) \_\_\_\_\_

Seizures Disorders \_\_\_\_\_

Colon Disease, (colitis, polyps, CANCER) \_\_\_\_\_

Other Cancers \_\_\_\_\_

Liver Disease \_\_\_\_\_

Esophageal Disorders \_\_\_\_\_

Kidney Disorders \_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_

**Allergies:** (Including Medications, latex, contrast material, iodine)

\_\_\_\_\_

\_\_\_\_\_

**Blood Transfusions:** (Date, amount)

\_\_\_\_\_

**Current Medications:** (Including non-prescription drugs)

\_\_\_\_\_

\_\_\_\_\_

**Amounts/duration:**

**Use of Cigarettes (tobacco products):** \_\_\_\_\_ **Alcohol:** \_\_\_\_\_

**Caffine use (coffee, tea, soft drinks):** \_\_\_\_\_

**Women:** Last menstrual period \_\_\_\_\_

Contraceptive Use & Type \_\_\_\_\_

**Any other Information:**

\_\_\_\_\_

\_\_\_\_\_