

MEDICAL HISTORY FORM

NAME :.....

Diabetes	Yes	No
Heart Disease	Yes	No
Lung disease	Yes	No
Kidney disease	Yes	No
Liver disease	Yes	No
Bleeding disorder	Yes	No
Glaucoma	Yes	No
Hepatitis B or C	Yes	No
Pregnant/breast feeding	Yes	No

Medications

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If you have circled yes to heart disease, lung disease kidney disease, liver disease, bleeding disorder **or if you have any other medical problems** please outline in more detail in the space below

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Drug Allergies

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Family history of gastroenterology or liver disease

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Have you had a colonoscopy after October 31st, 2019?

- Yes
- No

How did you hear about us?

- Have been here before
- Recommended by a friend/relative
- Recommended by GP

Previous operations

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Occupation.....
Height.....
Weight.....

I have been given the opportunity to read the Privacy Policy Yes No