VIASCAN of LAS COLINAS

# PATIENT HISTORY FORM

**Patient Name** (First, Last) _____ **Date of Birth:** ____/__/_____

**Gender** ☐ Male ☐ Female **Date of Exam:** ___/__/_____

Occupation _____ How Long? _____

For patients over the age of 50, have you had a baseline colonoscopy? ☐Yes ☐No

**Referred by:**

☐ WBAP (Brad Barton) ☐KRLD (Scott Sams) ☐ KSKY (Mark Davis) ☐ Postcard/ E-mail ☐ Internet

☐ Doctor: _____ ☐ Family/ Friend: _____

**Patient Status:**

☐ New Patient ☐ Returning Patient ☐ Diamond Luxury ☐ Firefighter/ Police Officer

**Do you have a history of the following:**

☐ Heart Disease
- ☐ Palpitations ☐ Atrial Fibrillation
- ☐ Stent ☐ Bypass

☐ Murmur

☐ High Blood Pressure

☐ High Cholesterol

☐ Diabetes

☐ Stroke

☐ Transient Ischemic Attacks (TIAs)

☐ Cancer

Type/ Stage: _____

Year: _____

☐ Other: _____

**Do you use tobacco products or e-cigs:**

☐ Cigarettes ☐ Dip/ Chew ☐ E-cigs ☐ No
How much per day: _____
How many years: _____

☐ Have you had a previous lung screening (CT Lung)?
☐Yes (If so, when? _____) ☐No

**Do you Exercise:**

☐ Yes ☐ No
Type: _____
How many min/hours: _____
How many times/ week: _____

**Do you consume alcohol:**

☐ Yes ☐ No
How much: _____
How often: _____
How many years: _____

**Do you consume caffeine:**

☐ Yes ☐ No
How much: _____
How often: _____

**Type of diet:**

☐ Regular ☐ Vegetarian ☐ Vegan ☐Paleo ☐ Diabetic ☐ Low Carb
☐ Low fat ☐ Low Cholesterol/ Heart healthy ☐ Other: _____

VIASCAN of LAS COLINAS

# PATIENT HISTORY FORM

**Please list all Over the Counter (OTC) medications (including supplements) that you take and how often and how much you take. Please bring a list to appointment if additional space is needed.**

Name/ Brand: _____ How much: _____ How often:_____
Name/ Brand: _____ How much: _____ How often:_____
Name/ Brand: _____ How much: _____ How often:_____
Name/ Brand: _____ How much: _____ How often:_____
Name/ Brand: _____ How much: _____ How often:_____
Name/ Brand: _____ How much: _____ How often:_____
Name/ Brand: _____ How much: _____ How often:_____
Name/ Brand: _____ How much: _____ How often:_____

**Please list all Prescription (Rx) medications (including supplements) that you take and how often and how much you take. Please bring a list to appointment if additional space is needed.**

Name/ Brand: _____ How much: _____ How often:_____
Name/ Brand: _____ How much: _____ How often:_____
Name/ Brand: _____ How much: _____ How often:_____
Name/ Brand: _____ How much: _____ How often:_____
Name/ Brand: _____ How much: _____ How often:_____
Name/ Brand: _____ How much: _____ How often:_____
Name/ Brand: _____ How much: _____ How often:_____
Name/ Brand: _____ How much: _____ How often:_____
Name/ Brand: _____ How much: _____ How often:_____
Name/ Brand: _____ How much: _____ How often:_____
Name/ Brand: _____ How much: _____ How often:_____
Name/ Brand: _____ How much: _____ How often:_____

**Please list all surgeries and the year the surgery occurred**.

Surgery_____ Year: _____
Surgery_____ Year: _____
Surgery_____ Year: _____
Surgery_____ Year: _____
Surgery_____ Year: _____
Surgery_____ Year: _____
Surgery_____ Year: _____

ViaScan of Las Colinas

# PATIENT HISTORY FORM

## Family History (parents):

Is your **mother** alive?

☐ Yes Age:_____ ☐ No Age at death: _____

Cause of Death: _____

**Does/did your mother have a history of?**

☐ Heart Disease

☐ Heart Attack ☐ Congestive Heart Failure ☐ Stent ☐ Bypass

☐ High Cholesterol

☐ High Blood Pressure

☐ Stroke

☐ Cancer

Type: _____

☐ None of the above

Is your **father** alive?

☐ Yes Age:_____ ☐ No Age at death:_____

Cause of Death: _____

**Does/did your father have a history of?**

☐ Heart Disease

☐ Heart Attack ☐ Congestive Heart Failure ☐ Stent ☐ Bypass

☐ High Cholesterol

☐ High Blood Pressure

☐ Stroke

☐ Cancer

Type: _____

☐ None of the above

VIASCAN of LAS COLINAS

# PATIENT HISTORY FORM

## Family History (siblings):

Total number of siblings: _____ Sisters: _____ Brothers_____

How many alive:_____ How many deceased_____

**Does/did your any of them have a history of? (PLEASE SPECIFY)**

- ☐ Heart Disease: _____
  - ☐ Heart Attack
  - ☐ Congestive Heart Failure
  - ☐ Stent
  - ☐ Bypass
- ☐ High Cholesterol _____
- ☐ High Blood Pressure: _____
- ☐ Stroke:_____
- ☐ Cancer_____
  Type: _____
- ☐ None of the above