

*This box is for Office Use Only*

**Reviewed and Updated:**

<b>Initial</b>	<b>Date</b>	<b>Initial</b>	<b>Date</b>	<b>Initial</b>	<b>Date</b>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**PATIENT REVIEW OF SYSTEMS**

Do you consider yourself generally:     healthy     not healthy     Other: \_\_\_\_\_

**Are you experiencing any of the following?** (Please check all that apply)

**Eyes:**                     Blurred vision                     Painful eyes                     Irritation from light                     None  
 Other: \_\_\_\_\_

**Ears, Nose, Throat and Mouth**     Sores in mouth                     Nose blocked                     Teeth hurt                     None  
 Post Nasal Drip                     Rhinitis (runny nose)                     Itching: where? \_\_\_\_\_  
 Pressure in ears                     Other: \_\_\_\_\_

**Cardiovascular (Heart)**     Pain in chest                     Palpitation/Fluttering of heart                     None  
 Shortness of breath while exercising                     Other: \_\_\_\_\_

**Respiratory (Lungs)**     Wheezing                     Cough                     Shortness of breath while sitting                     None  
 Other: \_\_\_\_\_

**Gastrointestinal (Stomach)**     Constipation                     Diarrhea                     Pain                     None  
 Reflux (heartburn)                     Other: \_\_\_\_\_

**Genitourinary**     Urination at night                     Pain when urinating                     Hesitation when urinating                     None  
 Other: \_\_\_\_\_

**Musculoskeletal**     Soreness                     Weakness                     Cramping                     None  
 Other: \_\_\_\_\_

**Integumentary (Skin)**     Itchy skin                     Rash                     Lesions: where? \_\_\_\_\_                     None  
 Dry skin                     Bleeding                     Other: \_\_\_\_\_

**Neurological (Nerves)**     Twitch                     Ringing in ears                     Dizziness/Vertigo                     None  
 Abnormal movements                     Fainting                     Other: \_\_\_\_\_

**Psychiatric**     Mood swings                     Situational stress                     Depression                     None  
 Other: \_\_\_\_\_

**Endocrine**     Hot flashes                     Hair loss/growth                     Heat intolerance                     None  
 Cold intolerance                     Other: \_\_\_\_\_

**Hematologic**     Bleed easily                     Night sweats                     Weight loss                     None  
 Other: \_\_\_\_\_

**Allergic**     Sneezing                     Eye irritation                     Reactions                     None  
 Other: \_\_\_\_\_

# GASTROENTEROLOGY ASSOCIATES, P.C.

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## PATIENT HISTORY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

**CHIEF COMPLAINT:** \_\_\_\_\_

**Drug Allergies:** \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

### HAVE YOU EVER HAD OR DO YOU HAVE (CHECK IF YES):

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Colitis              | <input type="checkbox"/> Crohn's Disease     | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney disease          |
| <input type="checkbox"/> Angina/heart attack | <input type="checkbox"/> Emphysema            | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Cancer: _____           |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Liver problems      | <input type="checkbox"/> Venereal disease: _____ |
| <input type="checkbox"/> Asthma/hay fever    | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Lung problems       | <input type="checkbox"/> Sleep apnea: _____      |
| <input type="checkbox"/> Birth defects       | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Mental illness      | <input type="checkbox"/> Other: _____            |
| <input type="checkbox"/> Bladder disease     | <input type="checkbox"/> Heart failure        | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Other: _____            |
| <input type="checkbox"/> Bleeding disorder   | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Thyroid problem     |  |

Surgeries/Injuries: \_\_\_\_\_

### HAS ANYONE IN YOUR FAMILY HAD:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Celiac Sprue<br>Relationship: _____   | <input type="checkbox"/> Crohn's Disease<br>Relationship: _____ | <input type="checkbox"/> Diabetes<br>Relationship: _____           | <input type="checkbox"/> Hepatitis<br>Relationship: _____ |
| <input type="checkbox"/> Liver Problems<br>Relationship: _____ | <input type="checkbox"/> Pancreatitis<br>Relationship: _____    | <input type="checkbox"/> Ulcerative colitis<br>Relationship: _____ | <input type="checkbox"/> Ulcers<br>Relationship: _____    |
| <input type="checkbox"/> Alcoholism                            | <input type="checkbox"/> Bladder Disease                        | <input type="checkbox"/> Headaches                                 | <input type="checkbox"/> Mental Illness                   |
| <input type="checkbox"/> Anemia                                | <input type="checkbox"/> Bleeding disorder                      | <input type="checkbox"/> Heart failure                             | <input type="checkbox"/> Kidney disease                   |
| <input type="checkbox"/> Angina/heart attack                   | <input type="checkbox"/> Emphysema                              | <input type="checkbox"/> HIV/AIDS                                  | <input type="checkbox"/> Stroke                           |
| <input type="checkbox"/> Arthritis                             | <input type="checkbox"/> Epilepsy or seizures                   | <input type="checkbox"/> Sexually transmitted disease              | <input type="checkbox"/> High blood pressure              |
| <input type="checkbox"/> Asthma/hay fever                      | <input type="checkbox"/> Glaucoma                               | <input type="checkbox"/> Lung problems                             | <input type="checkbox"/> Cancer: _____                    |
| <input type="checkbox"/> Birth defects                         | <input type="checkbox"/> Tuberculosis                           | <input type="checkbox"/> Thyroid problems                          | <input type="checkbox"/> Other: _____                     |

### DO YOU

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Exercise regularly?<br>Type: _____<br>How Often: _____ | <input type="checkbox"/> Use alcohol?<br><input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor<br>How often: _____<br>How many: _____ | <input type="checkbox"/> Use tobacco:<br><input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe<br><input type="checkbox"/> Snuff <input type="checkbox"/> Chewing tobacco<br>How often: _____ | <input type="checkbox"/> Use drugs:<br><input type="checkbox"/> Marijuana <input type="checkbox"/> Heroin<br><input type="checkbox"/> Cocaine <input type="checkbox"/> LSD <input type="checkbox"/> Crack<br>How often: _____ |
|---|---|---|---|

Occupation: \_\_\_\_\_

Have any children?  Y  N

How many: \_\_\_\_\_

**PLEASE COMPLETE REVERSE SIDE**