

GASTROENTEROLOGY ASSOCIATES, P.C.

PATIENT HISTORY

Patient Name: _____ Date of Birth: _____ Age: _____ Today's Date: _____

Referring Doctor: _____

CHIEF COMPLAINT: _____

Drug Allergies: _____

Current Medications: _____

Are you on: Plavix? _____ Coumadin? _____ Aspirin? _____ Anti-inflammatories: _____

PAST OR PRESENT MEDICAL CONDITIONS

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Angina/Heart Attack | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> GERD | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Barrett's Esophagus | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Heart Valve Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> STD |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Peptic Ulcer Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Colonic Polyps | <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Seizures/Epilepsy |
- Other: _____

PREVIOUS PROCEDURES: () None

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Abdominal Surgery
When: _____ | <input type="checkbox"/> Appendectomy
When: _____ | <input type="checkbox"/> Cholecystectomy(gallbladder)
When: _____ | <input type="checkbox"/> C-Section
When: _____ | <input type="checkbox"/> Gastric Bypass
When: _____ |
| <input type="checkbox"/> Heart Surgery
When: _____ | <input type="checkbox"/> Hernia Surgery
When: _____ | <input type="checkbox"/> Partial Hysterectomy
When: _____ | <input type="checkbox"/> Total Hysterectomy
When: _____ | <input type="checkbox"/> Vascular Surgery
When: _____ |
- Other Surgeries: _____

DIAGNOSTIC TESTS: () None

- | | | |
|---|---|--|
| <input type="checkbox"/> Colonoscopy
When: _____ | <input type="checkbox"/> Gastroscopy
When: _____ | <input type="checkbox"/> Flexible Sigmoidoscopy
When: _____ |
|---|---|--|

IMMUNIZATIONS: () None

- | | |
|---|---|
| <input type="checkbox"/> Hepatitis B
When: _____ | <input type="checkbox"/> Hepatitis A
When: _____ |
|---|---|

HAS ANYONE IN YOUR FAMILY HAD: () None

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Celiac Disease
Relationship: _____ | <input type="checkbox"/> Crohn's Disease
Relationship: _____ | <input type="checkbox"/> Colon Cancer
Relationship: _____ | <input type="checkbox"/> Colonic Polyps
Relationship: _____ |
| <input type="checkbox"/> Stomach Cancer
Relationship: _____ | <input type="checkbox"/> Gallstones
Relationship: _____ | <input type="checkbox"/> Ulcerative Colitis
Relationship: _____ | <input type="checkbox"/> Other:
Relationship: _____ |

SOCIAL HISTORY:

Occupation: _____

Number of Children: _____

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Exercise () None
Type: _____
How Often: _____ | <input type="checkbox"/> Alcohol () None
() Beer () Wine () Liquor
How often: _____
How many: _____ | <input type="checkbox"/> Tobacco () Never smoked
() Current every day smoker
() Current some day smoker
() Former smoker | <input type="checkbox"/> Drugs () None
() Marijuana () Heroin
() Cocaine () LSD () Crack
How often: _____ |
|---|--|---|--|

PLEASE COMPLETE REVERSE SIDE