

# 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        | <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"/> Seizures/Epilepsy  |   |

### PREVIOUS PROCEDURES: ( ) None

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

### DIAGNOSTIC TESTS: ( ) None

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

### IMMUNIZATIONS: ( ) None

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

### HAS ANYONE IN YOUR FAMILY HAD: ( ) None

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

### SOCIAL HISTORY:

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

Number of Children: \_\_\_\_\_

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Exercise ( ) None<br>Type: _____<br>How Often: _____ | <input type="checkbox"/> Alcohol ( ) None<br>( ) Beer ( ) Wine ( ) Liquor<br>How often: _____<br>How many: _____ | <input type="checkbox"/> Tobacco ( ) None<br>( ) Cigarettes ( ) Cigars ( ) Pipe<br>( ) Snuff ( ) Chewing tobacco<br>How often: _____ | <input type="checkbox"/> Drugs ( ) None<br>( ) Marijuana ( ) Heroin<br>( ) Cocaine ( ) LSD ( ) Crack<br>How often: _____ |
|---|--|--|--|

**PLEASE COMPLETE REVERSE SIDE**

PATIENT NAME: \_\_\_\_\_

## **PATIENT REVIEW OF SYSTEMS**

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

- |  |  |   |   |                               |
|--|--|---|---|-------------------------------|
| <u><b>Allergic</b></u>                   | <input type="checkbox"/> Eye irritation  | <input type="checkbox"/> Reactions  | <input type="checkbox"/> Sneezing   | <input type="checkbox"/> None |
| <u><b>Cardiovascular (Heart)</b></u>     | <input type="checkbox"/> Pain in chest<br><input type="checkbox"/> Shortness of breath while exercising  | <input type="checkbox"/> Palpitation/Fluttering of heart  |   | <input type="checkbox"/> None |
| <u><b>ENMT:</b></u>                      | <input type="checkbox"/> Blurred vision<br><input type="checkbox"/> Nose blocked<br><input type="checkbox"/> Pressure in ears<br><input type="checkbox"/> Teeth hurt | <input type="checkbox"/> Irritation from light<br><input type="checkbox"/> Painful Eyes<br><input type="checkbox"/> Rhinitis (runny nose) | <input type="checkbox"/> Itching<br><input type="checkbox"/> Post Nasal Drip<br><input type="checkbox"/> Sores in mouth | <input type="checkbox"/> None |
| <u><b>Endocrine</b></u>                  | <input type="checkbox"/> Cold intolerance<br><input type="checkbox"/> Hot flashes  | <input type="checkbox"/> Hair loss/growth   | <input type="checkbox"/> Heat intolerance   | <input type="checkbox"/> None |
| <u><b>Gastrointestinal (Stomach)</b></u> | <input type="checkbox"/> Constipation<br><input type="checkbox"/> Reflux (heartburn)   | <input type="checkbox"/> Diarrhea   | <input type="checkbox"/> Pain   | <input type="checkbox"/> None |
| <u><b>Genitourinary</b></u>              | <input type="checkbox"/> Hesitation when urinating   | <input type="checkbox"/> Urination at night   | <input type="checkbox"/> Pain when urinating  | <input type="checkbox"/> None |
| <u><b>Hematologic</b></u>                | <input type="checkbox"/> Bleeds easily   | <input type="checkbox"/> Night sweats   | <input type="checkbox"/> Weight loss  | <input type="checkbox"/> None |
| <u><b>Integumentary (Skin)</b></u>       | <input type="checkbox"/> Bleeding<br><input type="checkbox"/> Lesions  | <input type="checkbox"/> Dry Skin<br><input type="checkbox"/> Rash  | <input type="checkbox"/> Itchy Skin   | <input type="checkbox"/> None |
| <u><b>Musculoskeletal</b></u>            | <input type="checkbox"/> Cramping  | <input type="checkbox"/> Soreness   | <input type="checkbox"/> Weakness   | <input type="checkbox"/> None |
| <u><b>Neurological (Nerves)</b></u>      | <input type="checkbox"/> Abnormal movements<br><input type="checkbox"/> Ringing in the ears  | <input type="checkbox"/> Dizziness/Vertigo<br><input type="checkbox"/> Twitch   | <input type="checkbox"/> Fainting   | <input type="checkbox"/> None |
| <u><b>Psychiatric</b></u>                | <input type="checkbox"/> Depression  | <input type="checkbox"/> Mood Swings  | <input type="checkbox"/> Situational Stress   | <input type="checkbox"/> None |
| <u><b>Respiratory (Lungs)</b></u>        | <input type="checkbox"/> Cough<br><input type="checkbox"/> Fainting  | <input type="checkbox"/> Shortness of breath while sitting  |   | <input type="checkbox"/> None |