PATIENT REVIEW OF SYSTEMS

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

**Allergic**
- ( ) Eye irritation
- ( ) Reactions
- ( ) Sneezing
- ( ) None

**Cardiovascular (Heart)**
- ( ) Pain in chest
- ( ) Palpitation/Fluttering of heart
- ( ) None
- ( ) Shortness of breath while exercising

**ENMT:**
- ( ) Blurred vision
- ( ) Irritation from light
- ( ) Painful Eyes
- ( ) Rhinitis (runny nose)
- ( ) Itching
- ( ) Post Nasal Drip
- ( ) Sores in mouth
- ( ) None

**Endocrine**
- ( ) Cold intolerance
- ( ) Hair loss/growth
- ( ) Hot flashes
- ( ) Heat intolerance
- ( ) None

**Gastrointestinal (Stomach)**
- ( ) Constipation
- ( ) Diarrhea
- ( ) Pain
- ( ) Reflux (heartburn)

**Genitourinary**
- ( ) Hesitation when urinating
- ( ) Urination at night
- ( ) Pain when urinating
- ( ) None

**Hematologic**
- ( ) Bleeds easily
- ( ) Night sweats
- ( ) Weight loss
- ( ) None

**Integumentary (Skin)**
- ( ) Bleeding
- ( ) Lesions
- ( ) Dry Skin
- ( ) Rash
- ( ) Itchy Skin
- ( ) None

**Musculoskeletal**
- ( ) Cramping
- ( ) Soreness
- ( ) Weakness
- ( ) None

**Neurological (Nerves)**
- ( ) Abnormal movements
- ( ) Dizziness/Vertigo
- ( ) Fainting
- ( ) None
- ( ) Ringing in the ears
- ( ) Twitch

**Psychiatric**
- ( ) Depression
- ( ) Mood Swings
- ( ) Situational Stress
- ( ) None

**Respiratory (Lungs)**
- ( ) Cough
- ( ) Shortness of breath while sitting
- ( ) None
- ( ) Wheezing
GASTROENTEROLOGY ASSOCIATES, P.C.

PATIENT HISTORY

Patient Name: ___________________________________ Date of Birth: _______________ Age: ________ Today’s Date: ____________

Referring Doctor: __________________________________________________________________

CHIEF COMPLAINT: ________________________________________________________________

Drug Allergies: __________________________________________________________________

Current Medications: __________________________________________________________________


PAST OR PRESENT MEDICAL CONDITIONS

( ) Alcoholism  ( ) Diverticulosis  ( ) Angina/Heart Attack  ( ) Asthma  ( ) Anxiety
( ) Anemia  ( ) GERD  ( ) Heart Failure  ( ) Seasonal Allergies  ( ) Bipolar Disorder
( ) Barrett’s Esophagus  ( ) Hepatitis  ( ) Heart Valve Disease  ( ) Lung Disease  ( ) STD
( ) Colitis  ( ) Liver Disease  ( ) Hypertension (high blood pressure)  ( ) Emphysema/COPD  ( ) Depression
( ) Colon Cancer  ( ) Peptic Ulcer Disease  ( ) Stroke  ( ) Sleep Apnea  ( ) HIV/AIDS
( ) Crohn’s Polyps  ( ) Bladder Disease  ( ) Diabetes  ( ) Arthritis  ( ) Glaucoma
( ) Crohn’s Disease  ( ) Thyroid Disease  ( ) Kidney Disease  ( ) High cholesterol  ( ) Seizures/Epilepsy

Other: ___________________________________________________________________________

PREVIOUS PROCEDURES: ( ) None

( ) Abdominal Surgery  ( ) Appendectomy  ( ) Cholecystectomy(gallbladder)  ( ) C-Section  ( ) Gastric Bypass
When: ____________  When: ____________  When: ____________  When: ____________  When: ____________
( ) Heart Surgery  ( ) Hernia Surgery  ( ) Partial Hysterectomy  ( ) Total Hysterectomy  ( ) Vascular Surgery
When: ____________  When: ____________  When: ____________  When: ____________  When: ____________
( ) Other Surgeries: ________________________________________________________________________________________________

DIAGNOSTIC TESTS: ( ) None

( ) Colonoscopy  ( ) Gastroscopy  ( ) Flexible Sigmoidoscopy
When: ____________  When: ____________  When: ____________

IMMUNIZATIONS: ( ) None

( ) Hepatitis B  ( ) Hepatitis A
When: ____________  When: ____________

HAS ANYONE IN YOUR FAMILY HAD: ( ) None

( ) Celiac Disease  ( ) Crohn’s Disease  ( ) Colon Cancer  ( ) Colon Polyps
Relationship: ____________  Relationship: ____________  Relationship: ____________  Relationship: ____________
( ) Stomach Cancer  ( ) Gallstones  ( ) Ulcerative Colitis  ( ) Other:
Relationship: ____________  Relationship: ____________  Relationship: ____________  Relationship: ____________

SOCIAL HISTORY:

Occupation: ____________________
Number of Children: ______________
( ) Exercise ( ) None  ( ) Alcohol ( ) None  ( ) Tobacco ( ) Never smoked  ( ) Drugs ( ) None
Type: ______________  ( ) Beer ( ) Wine ( ) Liquor  ( ) Current every day smoker  ( ) Marijuana ( ) Heroin
How Often: ______________  How often: ______________  ( ) Current some day smoker  ( ) Cocaine ( ) LSD ( ) Crack
How many: ______________  ( ) Former smoker  How often: ______________