ASSOCIATES IN GASTROENTEROLOGY, PC

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Date of Appointment: _____/_____/_____ _____ Female _____ Male

Name: _____ Age: _____ Date of Birth: _____/_____/_____

Referring Physician: _____

Reason for visit today: _____

List any tests done for this problem already:

1) _____ 2) _____ 3) _____

List current medications with dosages including over-the-counter or herbal:

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

List Drug Allergies:

1) _____ 2) _____ 3) _____

MEDICAL HISTORY: List any illnesses or diseases that you are being treated for or have been treated for in the past: (diabetes, asthma)

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

SURGERIES OR OPERATIONS Year Surgeon City

1) _____

2) _____

3) _____

4) _____

SOCIAL HISTORY:

Do you smoke? _____ No _____ Yes _____ Past
Cigarettes per day _____
Do you drink alcohol? ____ No ____ Yes ____ Past
Daily alcohol intake: _____
Marital Status: _____ Single _____ Married _____ Divorced _____ Widowed _____ Separated

Do you use Intravenous Drugs? _____ No _____ Yes _____ Past
Daily intake of coffee/caffeinated beverages: _____
Have you received a blood transfusion? _____ No _____ Yes
Number of Children _____

FAMILY HISTORY:

Age Serious Health Problems Cause of Death

Father: _____

Mother: _____

Brother: _____

Sister: _____

Which of your family members have had any of the following:

Colon Cancer _____ Stomach Ulcer _____ Gallstones _____

Colitis _____ Breast Cancer _____ Pancreatitis _____

Colon Polyps _____ Liver Disease _____ Bleeding tendency/Anemia _____

REVIEW OF SYSTEMS

Have you the patient ever been diagnosed or having problems with any of the following? If yes, please check any that apply and explain in the space provided.

SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES
Gastrointestinal			**Hepatic**			**Endocrine/Metabolic**			**Ophthalmic**		
Diarrhea			Liver Disease			Diabetes			Cataracts		
Constipation			Hepatitis			Thyroid Disorders			Glaucoma		
Rectal Bleeding			Pancreatitis			Excessive Sweating			Blindness		
Change in BM's			**Cardiac**			Fatigue			Blurred Vision		
Weight loss			High blood pressure			**Neurologic**			**Ear, Nose, & Throat**		
Irritable Bowel (IBS)			Low blood pressure			Seizures			Loose Teeth		
Crohn's Disease			Irregular heartbeat			Weakness			Nosebleeds		
Ulcerative Colitis			Chest pain			Migraines			Hearing Loss		
Trouble swallowing			**Respiratory**			Previous stroke			Ringing in Ears		
Nausea			Asthma			**Musculoskeletal**			**Psychosocial**		
Vomiting			Shortness of Breath			Arthritis			Alcoholism		
Heartburn			Chronic Cough			Joint pain			Substance Abuse		
Abdominal Pain			Hoarseness			Back pain			Depression		
Rectal Pain			**Genitourinary**			Leg Cramps			Anxiety disorders		
Reflux			Kidney Disease			**Skin**					
Poor Appetite			Frequent urine infection			Rash					
Sore Throat						Bruises					