

**GASTROENTEROLOGY ASSOCIATES**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Primary Care/Family Physician: \_\_\_\_\_

**To Be Completed by Patient (Please Print)**

The following information is very important to your health. Please take the time to fully and completely fill out this information. We are counting on you.

**Do you have or have you ever been treated for any of the following?**

MD Provider Notes

Heart Disease/Attack/irregular heartbeat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Angina/Chest Pain/Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Rheumatic Fever/Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Asthma/Bronchitis/Emphysema/COPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Ulcers/Acid Reflux/Esophagitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Gallbladder Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Liver Disease/Hepatitis/Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Colitis/Crohn's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Irritable Bowel Syndrome (IBS)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Colon Polyps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hemorrhoids	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Disease of the Pancreas	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Stroke/Mini Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Depression/Psychiatric Problems/Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Seizure Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cholesterol Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Sleep Apnea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

**Do you have any medical problems not indicated above?**

**Surgical History**

Where/When

Previous Anesthesia/Sedation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Problems with Above?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Gallbladder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Appendectomy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Uterus/Tubes/Ovaries	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Stomach/Bowel/Colon	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Heart	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

Do you have any allergies? \_\_\_\_\_

Do you need antibiotics before procedures? \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Current medications including non-prescription drugs such as Aspirin, Ibuprofen, Tylenol, Laxatives, Herbs:**

Medication	Dosage	Medication	Dosage
1.		10.	
2.		11.	
3.		12.	
4.		13.	
5.		14.	
6.		15.	
7.		16.	
8.		17.	
9.		18.	

**Social History:**

Marital Status: Single Divorced Married Widow/Widower Who lives with you? \_\_\_\_\_

Do you smoke?  Yes  No How many packs a day? \_\_\_\_\_ For how many years? \_\_\_\_\_

If you quit smoking, when did you quit? \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, how many drinks per day? \_\_\_\_\_ Per week? \_ Per Month? \_\_\_\_

If you quit drinking alcohol, when did you quit? \_\_\_\_\_

Do you use or have used illicit/recreational drugs:  Yes  No If yes, what and how much? \_\_\_\_\_

Have you been immunized against Hep A?  Yes  No Hep B?  Yes  No Flu?  Yes  No

**Family History: OTHER THAN YOURSELF, have any members of your family has any of the following?**

		Family Relationship
Stomach Problems/Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Colon Cancer/Colon Polyps	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Gallbladder Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Disease of the Pancreas	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other Digestive Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Problems Like Yours	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other Significant Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

**Have you had any of the following tests?**

	Where/When	Results if Known
Blood Tests		
EKG		
X-Rays		
Ultrasound		
CAT Scan		
Upper Endoscopy		
Colonoscopy		
Stool Occult Bleed Test		
Other		

Reviewed by \_\_\_\_\_

Date \_\_\_\_\_