

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 _____