PATIENT NAME: _____ TODAY'S DATE: _____

Reason for your visit today: _____

Have you seen a gastroenterologist in the past? *Please be advised that we do not give second opinions.*
Name of last GI specialist: _____ City: _____

Are you allergic to any medications? _____ Which ones? _____

PREVIOUS TESTS	When	Ordering physician	Results
Colonoscopy			
EGD			
CT abdomen/pelvis			
Ultrasound/MRI			
Liver biopsy			
Other			

MEDICAL PROBLEMS (if yes, place check mark to the *right* of the condition)

Have you ever received chemo, radiation therapy or other treatment for a condition?

High blood pressure ____	Arthritis ____	Macular Degen. ____	Blood Clots ____
Diabetes ____	Asthma ____	Anemia ____	Cancer: ____
High cholesterol ____	Atrial fibrillation ____	Gout ____	HIV ____
Angina (chest pain) ____	BPH (enlarged prostate) ____	Bladder issues ____	Hepatitis B ____
Heart attack ____	COPD ____	Sleep apnea ____	Hepatitis C ____
Heart murmur ____	Thyroid problems ____	Liver problems ____	Crohn's ____
Stroke ____	Epilepsy ____	Kidney problems ____	Celiac ____
Heart problems ____	Glaucoma ____	Lung problems ____	Colitis ____
Allergies ____			

SURGERIES *(place an "x" next to all that apply)*

	MO/YR			MO/YR	
		Appendectomy (appendix)			Hip replacement
		Breast (mastectomy, augmentation)			Hysterectomy
		Back surgery			Knee (replacement, arthroscopy)
		Cataract			Open Heart # bypass:
		C-section how many?:			Valve replacement
		Gallbladder			Pacemaker
		Gastric bypass			Plastic surgery
		Hemorrhoidectomy			TURP
		Hernia repair			
		Other:			

HOSPITALIZATIONS

Dates (mo/yr)	Hospital	Reason

FAMILY HISTORY *(please circle your response and complete the question)*

Any family history of colon cancer, stomach cancer, polyps or GI diseases?				Y or N If:
Father: alive / deceased	Age:	Health problems/cause of death:		
Mother: alive / deceased	Age:	Health problems/cause of death:		
Sisters/Brothers: # Brothers ___	# Sisters ___		Are they healthy?	Y or N
Children: Sons ___	Daughters ___		Are they healthy?	Y or N

SOCIAL HISTORY *(place an "x" and give complete answers to all that apply)*

Marital Status: __ married __ divorced __ single __ widowed __ separated __ life partner

Blood transfusion	Y or N	If yes, when? Date(s):
Cocaine use		
Recreational drug use		Never / Current / Past Type(s):
IV Drug Use		Never / Current / Past
TATTOOS		How many?: Year they were done:
Sexually active		
Birth Place		Where:
Nursing Home resident		
Occupation		What do you do?
Tobacco		How many packs per day?
QUIT tobacco use		After how many years: How many packs per day?
Alcohol		How much per day?
Caffeine		How many cups coffee, cola or tea per day:
Travel outside US		Where:
Occupational exposure		What type:
Jehovah's Witness		
What is your birth year?		Have you ever been tested for Hepatitis C?

HISTORY & PHYSICAL *(place an "X" next to any symptoms that you are currently experiencing)*

Itchy eyes ____
Runny nose ____
Scratchy throat ____
Sinus congestion ____
Allergic reactions ____
_____
Moles ____
Rash ____
Hives ____
Hair loss ____
_____
Blurred vision ____
Eye irritation ____
_____
Nosebleeds ____
Shortness of breath ____
Vocal changes ____
Cough ____
_____
Chest pain ____
Leg swelling ____
Palpitations ____
_____
Abdominal pain ____
Rectal bleeding ____
Change in bowel habit ____

Weight loss ____
Nausea ____
Vomiting ____
Heartburn ____
Indigestion ____
Difficulty swallowing ____
Painful swallowing ____
Constipation ____
Diarrhea ____
Abnormal distension ____
Blood in stool ____
Vomiting blood ____
Black, tarry stools ____
Anal discomfort ____
Bloating ____
Gas ____
Hiccups ____
Stool incontinence ____
Fatigue ____
Feeling full early ____
Loss of appetite ____
Fever ____
Sclera ____
Edema ____
Flatulence ____
Jaundice ____

Hemorrhoids ____
_____
Blood in urine ____
Difficulty urinating ____
Frequent urination ____
Headache ____
Insomnia ____
Seizures ____
_____
Memory loss ____
Considering suicide ____
Depression ____
Anxiety ____
Sleep disturbances ____
_____
Joint pain ____
Leg cramps ____
Gout ____
_____
Heat intolerance ____
Excessive thirst ____
Excessive sweating ____
_____
Bleeding or bruising ____
Anemia ____
Past transfusion ____