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FILL OUT THESE FORMS IN ITS ENTIRETY

Name: _____ **Age**: _____ **DOB**: _____

Phone Number: _____ **Alt Number**_____

Email address:_____ OR **None**_____

Reason for visit?: _____

Primary Care Physician:_____**Phone**_____

Previous Gastroenterologist: _____**Phone**_____

Current Medications: (Including prescription, over the counter, herbals and vitamins)

	Medication	**Dose**	**Schedule**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Please list all medications you are allergic to, including the reaction (for example, nausea vomiting, rash, headache, etc.) OR No Known Drug Allergies_____

_____

_____

What is your preferred pharmacy?_____**Phone**_____

Pharmacy Address:_____

Patient Name: _____ **Date**: _____

Have you ever been diagnosed with the following?					
YES	**NO**		**YES**	**NO**	
		High blood pressure			Pancreatitis
		Heart Attack			Jaundice
		Stroke			Liver Disease Which type? Hepatitis ___
		Rheumatic Fever			Kidney disease
		Asthma			Gout
		COPD / Emphysema			Degenerative Joint Disease
		Tuberculosis or Exposure			Arthritis Type:
		Peptic ulcer disease			Epilepsy / Seizures
		GERD			Thyroid disease
		Hiatal Hernia			Anemia
		Crohn's Disease			Cancer Location?
		Ulcerative colitis			Depression
		Irritable bowel syndrome			Scarlet Fever
		High Cholesterol			Diabetes
		Congestive Heart Failure			Other:
		Irregular Heart Beat			Had Mammogram? Date: _____
		Colon Polyps			Pneumonia Vaccine? Year:_____

Have you had any of the following surgeries?							
YES	**NO**	**DATE**		**YES**	**NO**	**DATE**	
			Appendectomy				Vasectomy
			Tonsillectomy				Hysterectomy
			Adenoidectomy				Removal of ovaries
			Gall Bladder removal				C-Section
			Heart Surgery				Colonoscopy
			Hernia Repair				Endoscopy
			Tubal ligation				Other:

Which Physician performed your Endoscopy / Colonoscopy? _____

Where were these procedures performed? _____

Other hospitalizations_____

Patient Name: _____ **Date**: _____

Family History: **___ Unknown OR (Adopted) _____**

Parents:	Age	Living	Deceased	Health Problems
Mother				
Father				
Brothers:				
Sisters:				
Children:				

In your immediate family, is there a history of:

Colon Polyps? YES / NO Relationship: _____

Colon Cancer? YES / NO Relationship: _____

Liver Disease? YES / NO Relationship: _____

Social History: (Please circle)

Do you drink alcohol? YES / NO Beer___ Wine____liquor____

If yes, how many drinks? _____ **Drinks/Ounces/Beers** How often? **Daily/Weekly/Monthly**

If no, did you previously drink alcohol? YES / NO
If yes, when did you quit? _____

Do you drink caffeine? YES/NO **Coffee, Tea, Soda, Chocolate** **How Many A day_____?**

Have you ever used tobacco? YES / NO

If yes, what type Cigarettes / Cigars / Smokeless? How much? _____

If you smoked in the past, what age did you start?_____ stop? _____

Have you ever tried to quit? YES / NO When? ____ How long?_____Days / Weeks / Months
Why did you start smoking again? _____

Patient Name: _____ Date: **_____**

Hepatitis Risk questions:

If you have ever experienced any of the following events or conditions please mark the "yes" box at the end of the list.

•I.V. Drug use (injection with needles, even one time)
•Nasal drug use, such as cocaine
•Body piercing
•Tattoo
•Receive blood or plasma by transfusion prior to 1992
•Work in emergency room, operating room, doctor's office or blood bank
•Sexually transmitted disease

□ Yes □ No □ Unsure

Do you have any of the following symptoms?

YES	NO		YES	NO		YES	NO	
		Chills			Diarrhea			Headache
		Fever			Difficulty swallowing			Numbness
		Fatigue			Heartburn			Tremors
		Weight loss			Vomiting blood			Anxiety
		Double vision			Blood in stools			Depression
		Ear infections			Loss of appetite			Increased stress
		Eye pain			Black stools			Hives
		Nasal congestion			Nausea			Skin sores
		Sinus infection			Acid reflux			Rash
		Sore throat			Vomiting			Back pain
		Shortness of breath			Painful urination			Muscle pain
		Frequent cough			Blood in urine			Joint pain
		Painful breathing			Frequent urination			Easy bleeding
		Wheezing			Incontinence urination			Easy bruising
		Chest pain			Urinary retention			Lymph node disease
		Edema in legs			Cold intolerance			Asthma
		Palpitations			Excessive thirst			Food allergies
		Abdominal pain			Heat intolerance			Immunosuppression
		Constipation			Dizziness			Seasonal Allergies

Patient Name: _____ Date: _____