Patient History

Thank you for choosing us to be your Center for excellent Gastrointestinal care!

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Board Certified Gastroenterology & Hepatology

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Board Certified Nurse Practitioner

Patient Name: _____ **Date of Birth:** _____

Current Medications, Blood- Thinners, Laxatives, Vitamins, or Herbals *(include dosage and how often you take them)*:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Drug Allergies: _____ **No known Drug Allergies:** *(check box)* ☐

Other Allergies: _____ **No known Food Allergies:** *(check box)* ☐

Reason for Appointment: _____

*Write reason for this appointment or check ↓ box next to options between **1- 19.***

1	***Circle:*** Coughing / Coughing up Blood	☐	**12**	Abnormal Weight Loss	☐
2	***Circle:*** Vomiting / Vomiting Blood	☐	**13**	***Circle:*** Diarrhea/ Constipation	☐
3	Nausea	☐	**14**	Change in bowel habits	☐
4	Difficulty swallowing	☐	**15**	***Circle:*** Blood in Stools/ Rectal Bleeding	☐
5	Acid Reflux/ GERD	☐	**16**	***Circle:*** Rectal Pain / Itching	☐
6	Heartburn	☐	**17**	Hemorrhoids	☐
7	***Circle:*** Abdominal Pain/ Cramping	☐	**18**	Excessive Flatulence/ passing gas	☐
8	Chest Pain	☐	**19**	Bloating (holding Gas)	☐

Past Medical History (*Diagnosed*): *Check ↓ box next to all options that apply between **1- 34.***

1	Gastroesophageal Reflux Disease (GERD)	☐	20	HIV Positive	☐
2	Stomach Ulcer	☐	21	Diabetes Mellitus (High/Low Blood Sugar)	☐
3	Personal History Colon Cancer	☐		↳(diagnosed only—not pre-diabetes)	
4	***Circle:*** Personal History: Colon Polyps/ Rectal Polyps	☐	22	Heart Problems/ Disease/ High Risk	☐
5	Hiatal Hernia	☐		↳Type: _____	
6	Irritable Bowel Syndrome (IBS)	☐	23	Do you have a Heart Valve	☐
7	***Circle one:*** Diverticulitis / Diverticulosis	☐		↳Type: Mechanical / Tissue	
8	Crohn's Disease	☐	24	***Circle:*** Heart Pacemaker / Defibulator	☐
9	***Circle one:*** Colitis/ Ulcerative colitis	☐	25	***Circle:*** Stroke / Seizures	☐
10	***Circle one:*** Gallbladder Problems/ Gall Stone	☐	26	Asthma (only if you still have it)	☐
11	Pancreatic Disease	☐	27	Lung Disease	☐
12	***Circle one:*** Kidney Problems/ Kidney Stone	☐	28	Tuberculosis	☐
13	Liver Problems _____	☐	29	Complications with Anesthesia?	☐
14	Cirrhosis	☐		↳ Type of reaction: _____	
15	***Circle one:*** Hepatitis (A, B, C or other)	☐	30	Cancer	☐
	↳Would you like to be screened for Hepatitis? Yes/No			↳Type: _____	
16	Anemia	☐	31	Diagnosed Depression	☐
17	Past Blood Transfusions? Year(s) _____	☐	32	Thyroid Disease	☐
	↳Would have a Blood Transfusion if needed? Yes/No		33	↳ ***Circle one:*** Hypo / Hyper	
18	Bleeding Disorder	☐		Joint Replacement	☐
19	Hypertention (High Blood Pressure)	☐	34	***Circle:*** Glaucoma / Vision Problems	☐

Please flip over and complete backside also.

List Other Past Medical History:

List Surgical History/Date or Year:	**List Hospitalizations/Date or Year:**

Last Colonoscopy: _____ Last EGD: _____

Blood test in last 3 months: ***Circle***: Yes / No Recent Diagnostic Imaging: _____

Some illnesses are hereditary. Therefore, it is necessary to know your family history. We only need information on your blood-related family. Please do not give history on step-family, adopted family, or "in-laws."

Biological Family History: (Circle) **(List family history of GI related diseases, colon polyps, diabetes, any cancer.)**

Father:	Alive / Deceased	
Mother:	Alive / Deceased	
Grandparents:	Alive / Deceased	
Sibling(s):	Alive / Deceased	
Children:	Alive / Deceased	

Some information we ask may seem very personal. However, it is necessary to know this history as it may affect your current or future health. We appreciate your cooperation and understanding.

	Social History:	**(Circle)**	**(Additional Details)**
1	Do you Smoke/or Use Smokeless Tabacco:	Yes – No	***Year started:*** ***Year quit:*** Circle: ***Smoking / Chewing/ Dipping/ Other*** _____ Circle: ***Packs/ Cigs.*** smoked per: ***Day / Week / Occasionally***
2	Marital Status:	⇒	Circle: ***Married / Single / Widowed / Divorced / Separated / Live-with Partner***
3	Homosexual Activity:	Yes – No	***(Have you had sexual relations with the same sex anytime in your lifetime?)***
4	Active Multiple Sexual Partners:	Yes – No	***(Are you currently having sexual relations with more than one partner?)***
5	Water you drink?:	⇒	Circle: ***City Water/ Well Water / Bottled Water / Filtered Water***
6	Illicit/ Recreational/ IV Drugs:	Yes – No	***Year started:*** ***Year quit:*** ***Type:*** ***How many?:*** **taken per:** circle: ***Day / Week / Occasionally***
7	What type of learner are you?:	⇒	Circle: ***Visual / Audio / Hands-On / Comprehensive (learn easily)***
8	Can you read & write:	⇒	Circle: ***Can read / Can't read / Can write / Can't write***
9	Work Occupation:	Yes – No	***Type of work:***
10	Occupation Exposure	Yes – No	***Type of High Risk Exposure:***
11	Do you use Alcohol:	Yes – No	***Type:*** ***Quantity:***
12	Do you have any Tattoos:	Yes – No	***Year(s) you got tattoo:***
13	Do you drink Caffeine:	Yes – No	Circle: ***Coffee/ Tea / Soda / Energy drink or pill*** ***Quantity:***
14	Recent travel outside USA?:	Yes – No	***Countries & Year:***
15	Are you Claustrophobic?	Yes – No	***Do you normally have to be sedated for OPEN MRI's? Yes / No***

PLEASE MAKE SURE YOU HAVE YOUR G.I. RECORDS AND RECENT LABS FAXED TO US 706-548-0555.

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Height: _____ Weight: _____ BP: _____ / _____ HR: _____ Temp: _____