GASTROENTEROLOGY

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Name: ____ Date of Birth: ______________
First Middle (full) Last m/d/yr

Primary care provider: ___________________________ Referring physician: ______________________

Local Pharmacy:____ Mail Order Pharmacy:__________________
Name Location

Brief Reason for Visit today: ____

Medical History

Please circle Y (Yes) or N (No) next to any of the medical conditions you experience or have been diagnosed with. **If you circle Y (Yes)**, please answer any corresponding questions mentioned below.

Gastrointestinal: (upper)

GERD / Reflux	Y	N	Diminished appetite	Y	N
Heartburn	Y	N	Unintentional weight loss	Y	N
Mid / upper abdominal pain	Y	N	Nausea	Y	N
Indigestion	Y	N	Vomiting	Y	N
Difficulty swallowing	Y	N	Bloating / Belching / Gas	Y	N

1) Do you notice worsening of these symptoms with any of the following:

Red sauces (pizza, spaghetti, barbeque)	Y	N
Citric juices (orange juice, lemonade)	Y	N
Gluten products (wheat, rye, and barley)	Y	N

Other: ____

2) Do you take medication(s) for these symptoms such antacids? Y N

If yes, what medication(s) and dosage do you currently take? ____

3) Have you tried other medication(s) in the past for these symptoms? Y N

If yes, please specify which medication(s), dosage, and approximate dates of use:

______________________________ ______________________________ ______________________________

4) Have you ever had an endoscopy? Y N (If answered yes, please answer the following):

When: _________________ Where: _______________________ Provider: _______________________________

Gastrointestinal: (lower)

Change in bowel habits	Y	N	Anal fissure	Y	N
Diarrhea	Y	N	Diverticulosis	Y	N
Constipation	Y	N	Diverticulitis	Y	N
Rectal bleeding	Y	N	Colon polyps	Y	N
Hemorrhoids	Y	N	Colon cancer	Y	N

1) Have you ever had a colonoscopy? Y N (If answered yes, please answer the following):
When: _________________ Where: _______________________ Provider: _______________________________

2) Have you ever had colon surgery? Y N If yes, reason: _________________________________

3) Do you notice a change in bowel habits (diarrhea, constipation, etc.) with the following:

Dairy products (milk, cheese, yogurt)	Y	N
Gluten products (wheat, rye, and barley)	Y	N
Fatty foods (butter, cookies, fried foods)	Y	N

Other: ______________________________________

Gastrointestinal (other):

Abdominal pain Y N
Location: _________________

Gallbladder stones Y N
Year diagnosed: _________________

1) Have you had previous gallbladder surgery / removal? Y N If yes, what year? _________________

2) Do you notice a worsening in abdominal pain after eating a high fat meal? Y N

3) Have you had imaging done for your gallbladder / abdomen in the last year? Y N
If yes, what type of imaging (ultrasound, MRI, etc.) _______________ Facility performed at: __________________

Neurology:

Anxiety	Y	N	Seizures	Y	N	Drug use	Y	N
Depression	Y	N	Sleep disorder	Y	N	Fibromyalgia	Y	N
Migraines	Y	N	Alcoholism	Y	N			

Cardiovascular:

Anemia	Y	N	Heart attack	Y	N	Stroke	Y	N
Hypertension	Y	N	Heart disease	Y	N	High cholesterol	Y	N

Respiratory

Asthma	Y	N	Sleep apnea	Y	N	COPD	Y	N

Surgical History

1) **Have you ever had joint replacement surgery? (examples: knee, hip, heart valve) Y N**

   If yes, what joint(s) did you have replaced? (Please indicate right or left if applicable): ___________________________

2) **Please list all surgeries in the spaces provided. Please do not exclude childhood surgeries or "minor" surgeries.**

- ____
- ____
- ____
- ____
- ____
- ____
- ____
- ____

Family History

Please list all family members (parents, siblings, grandparents, aunts, uncles, children, etc.) that have been diagnosed with the following. Please include yourself if you have been diagnosed with the following:

Colon cancer: _________________________________

Breast cancer: _________________________________

Ovarian cancer: _________________________________

Uterine cancer: _________________________________

Cervical cancer: _________________________________

Colon polyps: _________________________________

Crohn's disease: _________________________________

Ulcerative colitis: _________________________________

Celiac Disease: _________________________________

Gallbladder disease: _____________________________

Social History

1) **Do you drink alcohol? Y N Former**
   a) Type: Beer Wine Hard Liquor
   b) How many servings on average are consumed: Daily? ______Weekly? ______ Monthly? ______ Yearly? ______

2) **Do you drink caffeine? Y N**
   a) Type: Coffee Tea Soda Energy drinks
   b) How many servings on average are consumed: Daily? ______Weekly? ______ Monthly? ______

3) **Do you use tobacco products? Y N Former**
   a) Type: Cigarettes Chewing tobacco Cigars Hookah
   b) How many packs per day do you OR did you smoke? _________________ How long (months/years): _____________
   c) What year did you quit? _____________ (leave blank if not applicable)

4) **Do you currently take any anti-inflammatory products (Aspirin, Ibuprofen, Aleve, etc.) Y N**
   a) Name of medication(s) and dosage: ____
   b) How many tablets do you take on average: Daily? ______Weekly? ______ Monthly? ______ Yearly? ______

Review of Systems

Please indicate any **new** or **worsening** symptoms that you are currently experiencing or have experienced in the **last 4 weeks** by checking the corresponding box.

General

- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Anorexia

Head and Face

- ☐ Face pain
- ☐ Blurred vision

ENT

- ☐ Sore throat
- ☐ Hoarseness

Cardiovascular

- ☐ Chest pain
- ☐ Palpitations
- ☐ Lightheadedness

Respiratory

- ☐ Shortness of breath
- ☐ Dry cough
- ☐ Productive cough
    - Clear sputum
    - Colored sputum
- ☐ Vomiting Blood

Gastrointestinal

- ☐ Abdominal pain
- ☐ Abdominal bloating
- ☐ Abdominal cramping
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal bleeding (bright red blood)
- ☐ Dark stools (melena)

Genitourinary

- ☐ Painful urination (dysuria)
- ☐ Urinary frequency
- ☐ Urinary urgency
- ☐ Blood in urine (hematuria)

Musculoskeletal

- ☐ Diffuse joint pain
- ☐ Muscle aches (generalized)
- ☐ Back pain
- ☐ Joint swelling

Neurological

- ☐ Headache
- ☐ Confusion
- ☐ Dizziness
- ☐ Tingling

Psychiatric

- ☐ Difficulty sleeping
- ☐ Anxiety
- ☐ Depression

Endocrine

- ☐ Night sweats
- ☐ Muscle weakness

Hematologic and Lymphatic

- ☐ Swollen glands
- ☐ Easy bleeding
- ☐ Jaundice

ALLERGIES

Medication	Reaction

MEDICATION LIST

Please list all prescription and non-prescription medicines and supplements you take regularly or occasionally. Include medications discontinued or changed in the **past 2 weeks**. This information is for your safety to avoid drug-drug interactions.

START DATE	NAME OF MEDICATION	DOSAGE AND DIRECTIONS	REASON FOR TAKING	DATE STOPPED