

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Referred by: \_\_\_\_\_ Referred for: \_\_\_\_\_

PCP if not the referring M.D.: \_\_\_\_\_ Other MD's: \_\_\_\_\_

**Social History:**

Occupation \_\_\_\_\_

Do you have a family member that is seen in this office?  No  Yes, who? \_\_\_\_\_

**Have you ever seen a doctor that treats the stomach, colon, liver, gallbladder, bile ducts or pancreas?**

Yes  No

Name/Date: \_\_\_\_\_ Name/Date: \_\_\_\_\_

(For Office Use Only)

B/P: \_\_\_\_\_ T: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ O<sup>2</sup> Sat: \_\_\_\_\_ Weight: \_\_\_\_\_

Height: \_\_\_\_\_

BMI Pamphlet  Smoking Pamphlet BMI: \_\_\_\_\_

**Are you experiencing any of the following symptoms? (Please check)**

Persistent cough (One which has lasted for 3 or more weeks)  Bloody Sputum  Night Sweats

Weight loss  Anorexia  Fever

**Are you experiencing any of the following upper GI symptoms? (Please check)**

Painful swallowing  Vomiting blood  Indigestion  Excessive belching

Food sticking  Reflux  Abdominal pain \_\_\_\_\_

Nausea  Heartburn  Weight loss

Vomiting  Loss of appetite  Early satiety (fill up too quickly)

**Are you experiencing any of the following lower GI symptoms? (Please check)**

Diarrhea  Black, tarry stool  Rectal pain

Constipation  Urgency  Incontinence (soiling)

Red blood in stool  Hemorrhoids  Gas/bloating

Straining  Rectal prolapse

**Elimination Habits:**

Number of bowel movements per day \_\_\_\_\_, per week \_\_\_\_\_.

Bowel movements are (please circle): hard, soft, formed, loose, watery, marble-like

Do you see pus or mucous in stool?  Yes  No

**Personal Habits:**

	Current	Past History
Daily tobacco use:	_____	_____ (Packs/how much snuff/chewing tobacco/cigars per day)
Alcohol use:	_____	_____ (drinks per day/week)
Daily caffeine use:	_____	_____ (cups or glasses of Coke, coffee or tea a day)
Dairy products:	_____	_____ (how many servings per day)
Herbal remedies:	_____	_____ (how much/how many times a day or week)
Illegal Drug Use	_____	_____ (drugs used _____)

Are you pregnant?  Yes  No

Are you nursing:  Yes  No

**Have you ever had any of the following x-rays of the stomach and/or colon (please check)**

		Where/Doctor who ordered	Results	Date (approx)
Barium enema:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Upper GI:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Small bowel:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Ultrasound of gallbladder:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
CT of abdomen:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Hida Scan:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Gastric emptying scan:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
MRI of the abdomen:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____

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**LABORATORY WORK:**

Have you had any recent lab work done?  Yes  No When: \_\_\_\_\_ Where: \_\_\_\_\_  
Have you had a recent EKG?  Yes  No When: \_\_\_\_\_ Where: \_\_\_\_\_

**Have you ever had your throat, stomach or intestines looked at with a lighted scope? (Please check)**

	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where/Doctor	Date (Approx)
Panendoscopy (stomach)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Colonoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Flexible sigmoidoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
ERCP	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Stretching of your esophagus	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

**Medical History: (please check)**

<b>ANESTHESIA</b> – Have you ever had trouble with it?.....	<input type="checkbox"/> Yes, what? _____	<input type="checkbox"/> No
<b>COMPLICATIONS</b> – Have you ever had any after procedures/surgery?	<input type="checkbox"/> Yes, what? _____	<input type="checkbox"/> No
Breathing problems / COPD/ Emphysema/ Asthma/ <b>Sleep Apnea</b> .....	<input type="checkbox"/> Yes (circle problems)	<input type="checkbox"/> No
Diabetes .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High blood pressure / TIA / Stroke .....	<input type="checkbox"/> Yes (circle problems)	<input type="checkbox"/> No
Heart disease/heart attack/heart surgery .....	<input type="checkbox"/> Yes (circle problems)	<input type="checkbox"/> No
Mitral valve prolapse .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you take antibiotics before dental or other procedures? .....	<input type="checkbox"/> Yes, why? _____	<input type="checkbox"/> No
Glaucoma .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizures .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis/yellow jaundice .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of hip or knee joint replacement .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any pins or screws in your body .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any recent antibiotic use .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ever been treated for <b>H. pylori</b> bacteria .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any cancer .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood transfusions (if “yes”, when _____) .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any recent stress .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any emotional problems (depression, panic attacks, etc.) .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any history of alcohol or drug abuse .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to pain management? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you taking any diet pills? .....	<input type="checkbox"/> Yes, what? _____	<input type="checkbox"/> No
Are you <b>HIV</b> Positive?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had chemotherapy or radiation therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Date of last flu shot? \_\_\_\_\_ Date of last pneumonia shot? \_\_\_\_\_

**Other Conditions:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Surgical History:**

	Surgery:	Date/Place:	Surgeon:
<b>Cardiac</b>	<input type="checkbox"/> coronary bypass	_____	_____
	<input type="checkbox"/> coronary stent	_____	_____
	<input type="checkbox"/> pacemaker insertion	_____	_____
	<input type="checkbox"/> internal defibrillator	_____	_____
	<input type="checkbox"/> heart valve replacement	_____	_____
<b>GI</b>	<input type="checkbox"/> anal fissure repair	_____	_____
	<input type="checkbox"/> colon resection	_____	_____
	<input type="checkbox"/> small bowel resection	_____	_____
	<input type="checkbox"/> gastrectomy (Bilroth I or II)	_____	_____
	<input type="checkbox"/> Nissen funduplication	_____	_____
	<input type="checkbox"/> gastric banding	_____	_____
	<input type="checkbox"/> gastric bypass	_____	_____
	<input type="checkbox"/> gallbladder	_____	_____
	<input type="checkbox"/> hemorroidectomy	_____	_____
<b>Orthopedic</b>	<input type="checkbox"/> Hip replacement	_____	_____
	<input type="checkbox"/> Knee replacement	_____	_____
	<input type="checkbox"/> Cervical spine	_____	_____
<b>Other surgeries</b>	<input type="checkbox"/> _____	_____	_____
	<input type="checkbox"/> _____	_____	_____
	<input type="checkbox"/> _____	_____	_____

**Family History:** (Any stomach/colon/liver problems/ uterine cancer/ kidney cancer)

Adopted	<input type="checkbox"/> unknown
Mother	<input type="checkbox"/> colon cancer <input type="checkbox"/> colon polyps <input type="checkbox"/> Crohn's <input type="checkbox"/> ulcerative colitis <input type="checkbox"/> other cancers/diseases _____
Father	<input type="checkbox"/> colon cancer <input type="checkbox"/> colon polyps <input type="checkbox"/> Crohn's <input type="checkbox"/> ulcerative colitis <input type="checkbox"/> other cancers/diseases _____
Brother	<input type="checkbox"/> colon cancer <input type="checkbox"/> colon polyps <input type="checkbox"/> Crohn's <input type="checkbox"/> ulcerative colitis <input type="checkbox"/> other cancers/diseases _____
Sister	<input type="checkbox"/> colon cancer <input type="checkbox"/> colon polyps <input type="checkbox"/> Crohn's <input type="checkbox"/> ulcerative colitis <input type="checkbox"/> other cancers/diseases _____
Maternal grandmother	<input type="checkbox"/> colon cancer <input type="checkbox"/> colon polyps <input type="checkbox"/> Crohn's <input type="checkbox"/> ulcerative colitis <input type="checkbox"/> other cancers/diseases _____
Maternal grandfather	<input type="checkbox"/> colon cancer <input type="checkbox"/> colon polyps <input type="checkbox"/> Crohn's <input type="checkbox"/> ulcerative colitis <input type="checkbox"/> other cancers/diseases _____
Paternal grandmother	<input type="checkbox"/> colon cancer <input type="checkbox"/> colon polyps <input type="checkbox"/> Crohn's <input type="checkbox"/> ulcerative colitis <input type="checkbox"/> other cancers/diseases _____
Paternal grandfather	<input type="checkbox"/> colon cancer <input type="checkbox"/> colon polyps <input type="checkbox"/> Crohn's <input type="checkbox"/> ulcerative colitis <input type="checkbox"/> other cancers/diseases _____
Children	<input type="checkbox"/> colon cancer <input type="checkbox"/> colon polyps <input type="checkbox"/> Crohn's <input type="checkbox"/> ulcerative colitis <input type="checkbox"/> other cancers/diseases _____

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**CURRENT:**

**Medications You Are Now Taking (including any over the counter medications, hormones and birth control pills):**

Drug/Mg/Frequency	Drug/Mg/Frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**PAST:**

**Have you ever used any of the following medications on a regular basis? (If 'YES', when, and did it work?)**

Aspirin containing medications (Goodies, Excedrin, Aspirin, Alka-Selzer)  Yes  No \_\_\_\_\_

Arthritis Medications (Nsaid, Motrin, Ibuprofen, Advil, Aleve, etc.)  Yes  No \_\_\_\_\_

Ulcer medications (Prilosec, Prevacid, Aciphex, Tagamet, Protonix, Nexium)  Yes  No \_\_\_\_\_

Stomach cramps medication (Librax, Levsin, Donnatal, Hyoscyamine, Bentyl NuLev, Zelnorm)  Yes  No \_\_\_\_\_

Nerve Pills (Xanax, Valium, Tranxene, Prozac, Zoloft, Paxil, etc.)  Yes  No \_\_\_\_\_

Blood thinners (Coumadin, Aspirin, Heparin, Xarelto, Plavix, Eliquis etc.)  Yes  No \_\_\_\_\_

Anti Nausea medicines {Phenergan, Zofran, Compazine}  Yes  No \_\_\_\_\_

Iron tablets  Yes  No \_\_\_\_\_

Laxatives (Correctol, Senokot, Lactulose, Miralax, Kristalose, etc.)  Yes  No \_\_\_\_\_

Herbal Product: \_\_\_\_\_  Yes  No \_\_\_\_\_

Medication to help stomach empty faster ( Reglan, Propulsid, etc.)  Yes  No \_\_\_\_\_

Fiber supplements (Metamucil, Fiber-Con, Citrucel, Konsyl, Equalactin)  Yes  No \_\_\_\_\_

Diet pills (Prescription or over-the-counter) \_\_\_\_\_  Yes  No \_\_\_\_\_

Antacids (Tums, Rolaids, etc.)  Yes  No \_\_\_\_\_

Questran powder, Cholestid, Welchol  Yes  No \_\_\_\_\_

Imodium, Lomotil or Pepto Bismol (for diarrhea)  Yes  No \_\_\_\_\_

Asacol, Pentasa, Prednisone, Imuran, Purinethol, Methotrexate, Remicade, Entyvio, Simponi, Humira, etc  Yes  No \_\_\_\_\_

Accutane  Yes  No \_\_\_\_\_

List pain medications you've used in the past  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies (Including medications, x-ray dye, latex, tapes, foods, etc.):**

\_\_\_\_\_  
\_\_\_\_\_

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_