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^2 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:	☐Yes ☐No	_____	_____	_____
Upper GI:	☐Yes ☐No	_____	_____	_____
Small bowel:	☐Yes ☐No	_____	_____	_____
Ultrasound of gallbladder:	☐Yes ☐No	_____	_____	_____
CT of abdomen:	☐Yes ☐No	_____	_____	_____
Hida Scan:	☐Yes ☐No	_____	_____	_____
Gastric emptying scan:	☐Yes ☐No	_____	_____	_____
MRI of the abdomen:	☐Yes ☐No	_____	_____	_____

Name:_____ Date of Birth:_____ Date:_____

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)

			Where/Doctor	Date (Approx)
Panendoscopy (stomach)	☐Yes	☐No	_____	_____
Colonoscopy	☐Yes	☐No	_____	_____
Flexible sigmoidoscopy	☐Yes	☐No	_____	_____
ERCP	☐Yes	☐No	_____	_____
Stretching of your esophagus	☐Yes	☐No	_____	_____

Medical History: (please check)

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

Date of last flu shot? _____ Date of last pneumonia shot?_____

Other Conditions:

_____

_____

_____

Name:_____ Date of Birth:_____ Date:_____

Surgical History:

	Surgery:	Date/Place:	Surgeon:
Cardiac	☐ coronary bypass	_____	_____
	☐ coronary stent	_____	_____
	☐ pacemaker insertion	_____	_____
	☐ internal defibrillator	_____	_____
	☐ heart valve replacement	_____	_____
GI	☐ anal fissure repair	_____	_____
	☐ colon resection	_____	_____
	☐ small bowel resection	_____	_____
	☐ gastrectomy (Bilroth I or II)	_____	_____
	☐ Nissen fundiplication	_____	_____
	☐ gastric banding	_____	_____
	☐ gastric bypass	_____	_____
	☐ gallbladder	_____	_____
	☐ hemoorhoidectomy	_____	_____
Orthopedic	☐ Hip replacement	_____	_____
	☐ Knee replacement	_____	_____
	☐ Cervical spine	_____	_____
Other surgeries			
	☐ _____	_____	_____
	☐ _____	_____	_____
	☐ _____	_____	_____

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

Adopted	☐ unknown				
Mother	☐ colon cancer	☐ colon polyps	☐ Crohn's	☐ ulcerative colitis	☐ other cancers/diseases _____
Father	☐ colon cancer	☐ colon polyps	☐ Crohn's	☐ ulcerative colitis	☐ other cancers/diseases _____
Brother	☐ colon cancer	☐ colon polyps	☐ Crohn's	☐ ulcerative colitis	☐ other cancers/diseases _____
Sister	☐ colon cancer	☐ colon polyps	☐ Crohn's	☐ ulcerative colitis	☐ other cancers/diseases _____
Maternal grandmother	☐ colon cancer	☐ colon polyps	☐ Crohn's	☐ ulcerative colitis	☐ other cancers/diseases _____
Maternal grandfather	☐ colon cancer	☐ colon polyps	☐ Crohn's	☐ ulcerative colitis	☐ other cancers/diseases_____
Paternal grandmother	☐ colon cancer	☐ colon polyps	☐ Crohn's	☐ ulcerative colitis	☐ other cancers/diseases_____
Paternal grandfather	☐ colon cancer	☐ colon polyps	☐ Crohn's	☐ ulcerative colitis	☐ other cancers/diseases_____
Children	☐ colon cancer	☐ colon polyps	☐ Crohn's	☐ ulcerative colitis	☐ other cancers/diseases_____

Name:_____ Date of Birth:_____ Date:_____

CURRENT:

Medications You Are <u>Now</u> 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 <u>regular</u> basis? (<u>If 'YES'</u>, when, and did it work?)

Aspirin containing medications (Goodies, Excedrin, Aspirin, Alka-Selzer) ☐Yes ☐No _____

Arthritis Medications (Nsaids, 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 _____
Please specify product

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 _____
Please specify product

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, <u>latex</u>, tapes, foods, etc.):

_____ _____ _____ _____

_____ _____ _____ _____

Reviewed By: _____ Date:_____