GASTROENTEROLOGY CONSULTANTS, P.C.

Name: _____ Birthdate ____/____/_____ Age: _____ Date: _____

Referring and/or Family Doctor(s): _____

Main Problem(s): _____

SYMPTOMS / SIGNS (How recent in past year?) Do you have:	No	Yes	Comment
Trouble swallowing			
Chest Pain			
Poor appetite			
Heartburn / Acid reflux			
Nausea & vomiting			
Abdominal pain			
Bloating/swelling			
Vomiting blood			
Blood in stool			
Constipation			
Diarrhea			
Rectal pain with BM			
Hemorrhoid trouble			
Avoid certain foods			

Change in size, shape and/or texture of BM

Describe _____

Weight: Now _____ 1 Year Ago _____

ALLERGIES / SENSITIVITIES: (List meds / reaction)

SURGERY	No	Yes	Date / Comment
Appendectomy			
Gallbladder			
Hysterectomy			
Abdominal (other)			
Other			

ILLNESSES (Please check)

Have you ever had:	No	Yes	Comment
Heart trouble			
Hypertension			
Anemia			
Lung disease			
Diabetes			
Cancer			
Gallstones			
Pancreatitis			
Hepatitis, Jaundice			
Ulcers, Gastritis			
Irritable bowel			
Crohn's or colitis			
Diverticulosis (-itis)			
Nervous trouble			
Other			

X-RAYS / PROCEDURES (Circle)	Dates / Comment
Upper GI / lower GI / small bowel X-ray	
Gallbladder: ultrasound / HIDA scan	
CT: abdomen / pelvis / other _____	
Scopes: upper / colon / sigmoid / ERCP	

Other or comments:

MEDICATIONS	Dose and Frequency

(List excess elsewhere or attach list)

PERSONAL (Circle and fill in, N = no, Y = yes)

Marital Status: S M D W Live-in Signf. other Year _____

Education / Occupation: _____

Tobacco: N Quit _____ Y _____ packs/wk X _____ yrs

Alcohol: N Quit _____ Y beer / wine / liquor Amt/wk _____

Aspirin/NSAIDS (ibuprofen/Aleve): N Y (list above)

Caffeine: N Y coffee / tea / soda pop Amt/wk _____

FAMILY (Provide age(s), status [↓ = deceased], health problems)

Father

Mother

Brother(s)

Sister(s)

Children

Polyps or Colon Cancer: N Y Who? _____

REVIEW OF SYSTEMS (Circle any current problems)

Fever, chills, fatigue, drowsiness, insomnia, headache _____

Change vision, hearing, balance, smell, taste (describe below)

Blood transfusions, HIV, tuberculosis, night sweats, infections

Sore throat, neck stiffness/swelling, thyroid disease, glands

Cough: day or night, asthma, short of breath, bronchitis, apnea

Rheumatic fever, palpitations, fainting, dizziness, leg swelling

Incontinence: bowel or bladder, fistula, fissure, abscess, polyps

Urinary: urgency, frequency, at night, burning, blood, stones

Discharge, irreg periods, endometriosis, Last period _____

Arthritis, back pain, weakness, numbness, tingling, seizures

Skin disease: rash, acne, psoriasis, eczema, fungus, cancer

Comments: