

GASTROENTEROLOGY CONSULTANTS, P.C.

Name: _____ Birthdate ___/___/___ Age: _____ Date: _____

Referring and/or Family Doctor(s): _____

Main Problem(s): _____

SYMPTOMS / SIGNS	(How recent in past year?)		Comment
Do you have:	No	Yes	
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: _____