Gastrointestinal Medicine Associates, Inc.

Name________________________________**Date of Birth**________________

Gastroenterology

Vomiting	O Yes	O No
Difficulty swallowing	O Yes	O No
Painful swallowing	O Yes	O No
Weight Loss	O Yes	O No
Heart Burn	O Yes	O No
Bloating	O Yes	O No
Pain after meal	O Yes	O No
Recent change in bowel habits	O Yes	O No
Constipation	O Yes	O No
Diarrhea	O Yes	O No
Rectal Bleeding	O Yes	O No
Poor appetite	O Yes	O No
Jaundice	O Yes	O No
Light colored stools	O Yes	O No
Dark Urine	O Yes	O No
Edema/Swelling	O Yes	O No

General

Fever/night sweats	O Yes	O No
Fatigue/weakness	O Yes	O No
Chronic cough	O Yes	O No
Nose bleeds	O Yes	O No
Sore throat	O Yes	O No

Cardiology

Dizziness	O Yes	O No
Chest pain	O Yes	O No
Palpitations	O Yes	O No
Shortness of breath	O Yes	O No
Pacemaker	O Yes	O No
Cardiac Defibrillator	O Yes	O No

Dermatology

Rash	O Yes	O No

Neurology

Seizure	O Yes	O No
Lightheaded/dizzy	O Yes	O No
Hematological		
Bleeding or bruising tendency	O Yes	O No
Anemia	O Yes	O No
Past transfusion	O Yes	O No
Swollen glands	O Yes	O No

Past Medical History

Asthma	O Yes	O No
High Blood pressure	O Yes	O No
High Cholesterol	O Yes	O No
Heart disease	O Yes	O No
Diabetes Mellitus	O Yes	O No
Irritable bowel Syndrome	O Yes	O No
Diverticulitis	O Yes	O No
GERD/Reflux	O Yes	O No
Hiatal hernia	O Yes	O No
Hemorrhoids	O Yes	O No
Colon cancer	O Yes	O No
Colon polyp	O Yes	O No
Gall stones	O Yes	O No
Hepatitis C	O Yes	O No
Hepatitis B	O Yes	O No
Peptic ulcer disease	O Yes	O No
Liver disease	O Yes	O No
Pancreatitis	O Yes	O No
Ulcerative colitis	O Yes	O No
Crohn's Disease	O Yes	O No
Celiac Disease	O Yes	O No
Metal Implants (i.e. joint replacement)	O Yes	O No

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Name________________________________ **Date of Birth**______________

Social History

Marital status O Yes O No
Travel O Yes O No
Tattoos O Yes O No
Cocaine O Yes O No
IV Drugs O Yes O No
Caffeine O Yes O No
Smoking O Yes O No packs/day_____how long_____quit____
Alcohol O Yes O No drinks/day_____drinks/week_____

Family History

Mother O Alive O Deceased Age__________
O Colon cancer O Inflammatory bowel disease O Liver disease
O Other____

Father O Alive O Deceased Age__________
O Colon cancer O Inflammatory bowel disease O Liver disease
O Other____

Siblings O Alive O Deceased Age__________
O Colon cancer O Inflammatory bowel disease O Liver disease
O Other____

Children O Alive O Deceased Age__________
O Colon cancer O Inflammatory bowel disease O Liver disease
O Other____

Surgical History-Please list all surgeries

____

____

Medication List

Do you take:

Aspirin O Yes O No
Over the counter
pain medication O Yes O No
Diabetes medication O Yes O No
Plavix, Coumadin, or
other blood thinner O Yes O No

ALLERGIES: ____

Signature:___________________________________**Date:**_______________