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

OVER

Gastrointestinal Medicine Associates, Inc.

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, including Colonoscopy

_____

_____

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:**_____