Associates in Gastroenterology Patient Health Information Form

Patient Name: **Date:** _____

SS# ...-..- _____ **Date of Birth** _____ **Age** _____ **Occupation** _____

Referring Physician: _____ **Primary Care Physician:** _____

Pharmacy: _____ **Pharmacy Location/ Phone#** _____
(All new prescriptions and refill prescriptions will be submitted electronically to your designated pharmacy)

What is the reason you are here today?_____

_____

Have you had any of the following regarding this problem: (Circle all that apply)

Blood Test, CT Scan, MRI, Ultra-sound, X-ray, Medication: _____

Other_____

***Chief Complaint*: What are your current symptoms: (Check All That Apply)**

	Yes	No		Yes	No		Yes	No		Yes	No
Abdominal Pain			Weight Loss			Alterations of bowel habits			Night Sweats		
Heartburn			Loss of appetite			Black tarry stools			Cough		
Indigestion			Bloating/ Flatulence			Rectal bleeding			Food Intolerance		
Difficulty swallowing			Excessive Gas			Hoarseness			Fever		
Painful swallowing			Constipation			Sore throat					
Nausea / vomiting			Diarrhea			Fatigue					

Your Past Medical History **(Check All That Apply)**

	Yes	No		Yes	No		Yes	No		Yes	No
Diverticulosis			Hepatitis			Anemia			Bleeding tendencies		
Irritable bowel/ spastic colon			Pancreatitis			Shortness of Breath			High Cholesterol		
Colonic or Gastric Polyps			Cirrhosis			Asthma			Hypothyroidism		
Colon Cancer			Liver disease			Emphysema			Diabetes		
Ulcerative Colitis			Breast Cancer			Positive TB skin test			Kidney Problem		
Other Colitis			Prostate Cancer			Coronary Artery Disease			Urinary Problem		
Ulcer Disease			Liver Cancer			Heart Attack			Anxiety/ Depres		
			Other Cancer Type_____			High Blood Pressure			Other_____		

Your Past Surgical History: (Check All That Apply)

	Colonoscopy	Colon Resection	EGD	ERCP	Aneurysm Repair	Gallbladder	Gastric Bypass	Hysterectomy	Joint Replacement	Heart Valve Replacement	Heart Surgery	Spleen Removal	Trouble with anesthesia
Yes													
No													

***Other Surgeries*:**_____

FAMILY HISTORY (Check All that Apply

	Colon Cancer	Other Cancer	Colonic or Gastric Polyps	Crohns	Ulcerative Colitis	Hepatitis	Hiatal Hernia	Irritable Bowel	Pancreatic Disease	Liver Disease	Ulcers	Coronary Artery	Heart Attack	High Blood Pressure	Diabetes
Mother															
Father															
Brother															
Sister															
Son															
Daughter															
Maternal Grandparent															
Paternal Grandparent															

Medications: **(List All Prescription and Over the Counter Medications that you are currently taking)**

Name of Medication	Dosage	# times / day	Reason for taking this medication
Do you take aspirin daily? Yes / No			

Are you allergic to:	Yes	No	Reaction
Penicillin			
Sulfa			
Antibiotic			
X-Ray Dye			
Sedatives			
Other			

Social History: (Check All That Apply)

Tobacco Use: None 1 pk/day _____ 1+pk/day_____ Year Stopped____

Alcohol Use: None Social 1/day 2-3/day 4+day Year Stopped____

Caffeine Use: Coffee_____cups/day Tea_____/day Cola Drinks_____/day

Street Drugs: Never_____ In the past_____ Occasionally_____ Frequently_____

Patient Signature: _____