

Date: _____

Name: _____ Age: _____ Gender: _____ Race: _____

Have you ever been seen by a physician in our practice? Yes No If Yes, when _____

Which physician are you scheduled to see today? _____

Which physician referred you to our office for consultation? _____

Who is your primary care physician? _____

PRESENTING COMPLAINT Briefly describe the reason for your visit.

REVIEW OF SYSTEMS Please check any symptoms you are **currently** experiencing.

Digestive Tract

- Nausea/Vomiting
- Trouble swallowing
- Painful swallowing
- Heartburn
- Indigestion/belching
- Abdominal pain
- Bloating/gas
- Change in bowel habits
- Diarrhea
- Fecal incontinence
- Constipation
- Blood in stool
- Black stools
- Hemorrhoids
- Rectal Pain/itching

General

- Change in appetite
- Fever
- Chills
- Fatigue
- Night sweats
- Weight loss _____ lbs
- Weight gain _____ lbs

Heart/Lungs

- Cough
- Coughing blood
- Sputum production
- Wheezing
- Chest pain
- Shortness of breath
- Swelling in legs
- Heart murmur
- Palpitations

Head

- Headaches
- Double vision
- Eye pain
- Sensitivity to light
- Vision loss
- Hearing loss
- Ringing in ears
- Vertigo
- Nosebleeds
- Nasal congestion
- Sinusitis
- Bleeding gums

Genitourinary

- Blood in urine
- Frequent urination
- Painful urination
- Kidney stones
- Urinary incontinence

Endocrine

- Enlarged thyroid
- Hair loss

Neurological

- Dizziness
- Loss of memory
- Numbness/tingling
- Tremor

Skin

- Itching
- Jaundice
- Lesions
- Rash

Musculoskeletal

- Back pain
- Joint pain
- Muscle cramps
- Neck pain
- Neck stiffness

Blood

- Anemia
- Blood transfusion
- Date: _____
- Easy bleeding/bruising
- Enlarged lymph nodes

Immune

- Allergies, food
- Allergies, environmental/seasonal

Women Only

- Breast lump
- Breast pain
- Abnormal menstrual cycle
- Vaginal discharge

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HEALTHCARE MAINTENANCE

If you are 50 years of age or older, have you had the following?

- Colonoscopy Yes No Date: _____
- Flexible Sigmoidoscopy Yes No Date: _____
- Barium Enema Yes No Date: _____
- Stool Test for Blood (Hemoccult) Yes No Date: _____
- Prostate Exam and PSA (Blood test) Yes No Date: _____

Have you ever had an upper GI series or gastroscopy? Yes No Date: _____

Have you had the following vaccinations:

- Influenza (Flu) Yes No Date: _____
- Pneumococcal Yes No Date: _____
- Hepatitis A Yes No Date: _____
- Hepatitis B Yes No Date: _____

PAST MEDICAL HISTORY Please check the following medical conditions which apply to you.

- Colon polyps Sleep apnea
- Blood Thinner Asthma
- Type: _____ Seizures
- Heart problems Cancer **Type:** _____
- AFib Thyroid problems _____
- CHF Diabetes _____
- Stents _____ High cholesterol _____
- Stroke Kidney disease _____
- COPD Hepatitis **Type:** _____
- High blood pressure Other _____

PAST SURGICAL HISTORY Please check the following surgeries that you have had in the past.

- | | | | | | |
|--|-------|------|--|-------|------|
| <input type="checkbox"/> Cholecystectomy (Gallbladder removal) | _____ | Date | <input type="checkbox"/> Pancreatic Surgery | _____ | Date |
| <input type="checkbox"/> Colon Surgery | _____ | | <input type="checkbox"/> Liver Surgery | _____ | |
| <input type="checkbox"/> Appendectomy | _____ | | <input type="checkbox"/> Other GI Surgeries: | _____ | |
| <input type="checkbox"/> Cancer | _____ | | _____ | _____ | |
| <input type="checkbox"/> Diverticular disease | _____ | | _____ | _____ | |
| <input type="checkbox"/> IBD (Crohn's, Ulcerative Colitis) | _____ | | _____ | _____ | |
| <input type="checkbox"/> Bleeding | _____ | | _____ | _____ | |
| <input type="checkbox"/> Obstruction | _____ | | _____ | _____ | |
| <input type="checkbox"/> Perforation | _____ | | _____ | _____ | |
| <input type="checkbox"/> Hemorrhoidectomy | _____ | | <input type="checkbox"/> Hysterectomy | _____ | |
| <input type="checkbox"/> Other: _____ | _____ | | <input type="checkbox"/> Other Surgeries: | _____ | |
| <input type="checkbox"/> Stomach Surgery | _____ | | _____ | _____ | |
| Type: <input type="checkbox"/> Lap Nissen | _____ | | _____ | _____ | |
| <input type="checkbox"/> Ulcer disease | _____ | | _____ | _____ | |
| <input type="checkbox"/> Cancer | _____ | | _____ | _____ | |
| <input type="checkbox"/> Bariatric (weight loss surgery) | _____ | | _____ | _____ | |
| Type: <input type="checkbox"/> Lap Band | _____ | | _____ | _____ | |
| <input type="checkbox"/> Gastric Sleeve | _____ | | _____ | _____ | |
| <input type="checkbox"/> RYGB | _____ | | _____ | _____ | |
| <input type="checkbox"/> Other | _____ | | _____ | _____ | |
| <input type="checkbox"/> Other _____ | _____ | | _____ | _____ | |

Name: _____

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FAMILY HISTORY

Patient is adopted. Family history unknown.

Father's Age _____ If deceased, age at death and cause _____

Mother's Age _____ If deceased, age at death and cause _____

Total number of brothers and sisters you have had _____

Do you have any **immediate family members** that have ever had the following:

<input type="checkbox"/>	Colon Polyps	Relative: _____	Age at Diagnosis: _____
<input type="checkbox"/>	Colon Cancer	Relative: _____	Age at Diagnosis: _____
<input type="checkbox"/>	Liver Disease	Relative: _____	Age at Diagnosis: _____
<input type="checkbox"/>	Diabetes	Relative: _____	Age at Diagnosis: _____
<input type="checkbox"/>	Heart Disease	Relative: _____	Type of Heart Disease: _____
<input type="checkbox"/>	Other Cancers	Relative: _____	Type of Cancer: _____
<input type="checkbox"/>		Relative: _____	Type of Cancer: _____
<input type="checkbox"/>	Other Illnesses	Relative: _____	Type of Illness: _____
		Relative: _____	Type of Illness: _____

SOCIAL HISTORY

What city do you live in? _____

Occupation? _____

Marital status? Single Married Divorced Widowed

Number of children? _____

Do you smoke/chew tobacco? Yes No Former Social

How many years? _____

Packs per day? _____

Do you drink alcohol? Yes No Former Social

Number of drinks? _____

Have you ever used illicit/intravenous drugs? Yes No

Have you ever snorted drugs? Yes No

Have you ever had a body piercing? Yes No

Have you ever had a tattoo? Yes No

