GASTRO HEALTH

FORMERLY ASSOCIATES IN GASTROENTEROLOGY

Patient's Name:	DOB:	Today's Date:
Primary Physician:		
Referring Physician:		

Reason for your visit:

_____

_____

_____

Current Medicines: (name and dose) ** AIG can only refill medications prescribed by our office*

1.	Refill Needed: Y N	7.	Refill Needed: Y N
2.	Refill Needed: Y N	8.	Refill Needed: Y N
3.	Refill Needed: Y N	9.	Refill Needed: Y N
4.	Refill Needed: Y N	10.	Refill Needed: Y N
5.	Refill Needed: Y N	11.	Refill Needed: Y N
6.	Refill Needed: Y N	12.	Refill Needed: Y N

Personal Medical History:

□ Acid Reflux	□ Colitis	□ Hepatitis	□ Osteoporosis
□ Alcoholism	□ Depression	□ High blood pressure	□ Stroke
□ Anemia	□ Diabetes	□ High cholesterol	□ Substance abuse
□ Anorexia/bulimia	□ Diverticulosis	□ HIV	□ Thyroid disease
□ Arthritis/gout	□ Emphysema	□ Irritable bowel	□ Tuberculosis
□ Asthma	□ Epilepsy/seizures	□ Kidney disease	□ Ulcers (stomach)
□ Blood clots	□ Gallstones	□ Liver disease	□ Ulcerative colitis
□ Cancer	□ Heart disease	□ Lung disease	□ Uterine bleeding
□ Crohn's Disease	□ Heart arrhythmia	□ Mental illness	
Others (please provide details):			

Medication allergies or reactions: (name and type of reaction)

1.
2.

Patient's Name: _____ Today's Date: _____

Previous GI Procedures (year, results, doctor's name):

Colonoscopy:
Sigmoidoscopy:
Upper Endoscopy (EGD):
Video Capsule studies (Pillcam):

Previous Surgeries (type and year):

1.
2.
3.
4.
5.
6.

Previous Hospitalizations (diagnosis or reason, year, which hospital):

1.
2.
3.

Family Medical History:

Check (√) and provide details:	Medical details about your family (diseases, types of cancer, etc.):
□ Colon cancer/polyps	Father:
	Mother:
□ Crohn's disease, ulcerative colitis	Siblings:
□ Liver disease or hepatitis	
□ Pancreatic cancer	Children:
□ Gall bladder disease	Paternal grandfather:
□ Stomach or esophagus cancer	Paternal grandmother:
□ Diabetes	Maternal grandfather:
□ Coronary artery disease	Maternal grandmother:

Personal Information:

Marital status:
Occupation:
Alcohol use:
Tobacco use:
Country of birth:

Patient's Name: _____ Today's Date: _____

Review of Symptoms:
Do you currently have any of these symptoms?

General:
□ Change in general health
□ Change in strength/stamina
□ Fevers/sweats

Endocrine:
□ Unusual change in weight
□ Fatigue/lethargy
□ Change in appetite

Heart and Circulation:
□ Chest pain
□ Palpitations
□ Swelling in legs

Lungs:
□ Cough
□ Shortness of breath
□ Wheezing

Neurologic:
□ Headache
□ Poor balance
□ Tingling in fingers/toes

Muscles/ Bones:
□ Joint aches
□ Muscle weakness/pain

Mood:
□ Anxiety/depression
□ Poor sleep
□ Difficulty concentrating

Allergy:
□ Hives/swelling
□ Allergic reaction to medicine

Eyes:
□ Change in vision
□ Eye pain

Ears, Nose, Throat:
□ Hearing loss
□ Nose bleeds
□ Sore throat/voice changes

Skin:
□ Rash
□ Discoloration
□ Hair Loss

Genito-Urinary:
□ Difficulty urinating
□ Blood in urine
□ Change in sexual function

Stomach/ Intestines/ Digestion:
□ Nausea
□ Vomiting
□ Heartburn
□ Abdominal pain
□ Difficulty swallowing
□ Bloating/gas
□ Blood in stool
□ Change in bowel habits
□ Diarrhea
□ Constipation
□ Belching
□ Rectal bleeding
□ Abnormal bowel sounds
□ Hemorrhoids

Other:
□ _____

□ **Please check this box, IF, In the event wait times are prolonged, are you willing to have the available PA/NP start your visit to expedite your care?**