PREMIER GASTROENTEROLOGY

PATIENT HISTORY

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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

Name: _____ Date: _____

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

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

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

Name: _____ Date: _____

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:

☐	Colon Polyps	Relative:		Age at Diagnosis:	
☐	Colon Cancer	Relative:		Age at Diagnosis:	
☐	Liver Disease	Relative:		Age at Diagnosis:	
☐	Diabetes	Relative:		Age at Diagnosis:	
☐	Heart Disease	Relative:		Type of Heart Disease:	
☐	Other Cancers	Relative:		Type of Cancer:	
☐		Relative:		Type of Cancer:	
☐	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

Name: _____ Date: _____

MEDICATIONS List all prescription, over the counter and herbal medications you are taking including the dosage or number of pills per day.

☐ I currently take no medications.

Medication	Dose	Frequency

DRUG ALLERGIES List all medications to which you are allergic and the kind of reaction you experienced.

☐ I do not have any drug allergies.

Allergy	Reaction

Date Patient or Responsible Party Signature Physician Signature