Gastroenterology Associates - Screening History

Patient: ______________________ Phone: ______________
DOB: ______________________ Age: ______________
Referring Dr. ______________________ Date: ______________

SCREENING MEDICAL HISTORY: Please fill out this form as completely as possible. The doctor will be able to obtain essential data about you thereby enabling him to concentrate on your areas of concern. Thank you for your assistance.

Reason for Visit: ____

Allergies:

Your Medical History

Hypertension	Y / N
Heart attack	Y / N
Rheumatic Fever	Y / N
Diabetes	Y / N
Asthma/COPD	Y / N
Emphysema	Y / N
Stroke	Y / N
Arthritis	Y / N
Osteoporosis	Y / N
Heart Bypass	Y / N
Hysterectomy	Y / N
Gallbladder Removed	Y / N
Prostate Cancer	Y / N
Appendectomy	Y / N

Your Social History

Smoking Y / N _____ packs/day

Alcohol Y / N _____ drinks/day

Coffee/Tea/Cola _____ cups/day

Married Y/N

Occupation ______________

Family History

Colon Cancer	Y / N
Ulcers	Y / N
Liver Disease	Y / N
Gallbladder Disease	Y / N
Colitis	Y / N
Pancreas Disease	Y / N

OTHER:

____

Please Circle any of these that applies to you:

Weight Loss:	Y / N
How much past 3 months?	________
Loss of Appetite:	Y / N
Heartburn:	Y / N
How many years?	________
Use antacids	Y / N
Trouble Swallowing: Solids	Y / N
Liquids	Y / N
Pain with Swallowing:	Y / N
Abdominal Pain:	Y / N
Relieved by food	Y / N
Relieved by antacids / Zantac	Y / N
Wakes you up at night	Y / N
Nausea/Vomiting:	Y / N
History of Ulcer Disease	Y / N
History of Pancreatitis	Y / N
History of Liver Disease	Y / N

History of Viral Hepatitis	Y / N
Pain after eating greasy food	Y / N
History of Gallbladder disease	Y / N
History of IBS	Y / N
History of Lactose Intolerance	Y / N
History of Colitis	Y / N
Change in bowel movements:	Y / N
Pencil like stools	Y / N
Diarrhea:	Y / N
How long?	________
Constipation:	Y / N
How long?	________
Use Laxatives Routinely	Y / N
Bloody Bowel Movements:	Y / N
How long?	________
Mixed in stool?	Y / N
Black Bowel Movements:	Y / N
How long?	________

Fevers	Y / N	Eye redness/pain	Y / N	Short of Breath	Y / N	Rash	Y / N
Chills	Y / N	Mouth Sores	Y / N	Chest Pain	Y / N	Joint Pains	Y / N
Fatigue	Y / N	Chronic Cough	Y / N	New Wheezing	Y / N	Burning Urine	Y / N

If you feel your doctor should know anything more about you please write it down below. Thank you.

Gastroenterology Associates - Medication List

Patient: ____________________ Phone: __________

DOB: ____________________ Age: __________

Referring Dr. ____________________ Date: __________

Medication List

Over the counter meds. **Allergies**

OFFICE USE ONLY

Prescription	Dose	Frequency	Continue
			YES / NO
			YES / NO
			YES / NO
			YES / NO
			YES / NO
			YES / NO
			YES / NO
			YES / NO
			YES / NO
			YES / NO
			YES / NO