SHAREDID-1

Gastroenterology Associates - Screening History

Patient: _____ Phone: _____

DOB: _____ Age: _____

Referring Dr. Date:

Reason for Visit: _____

When was your last colonoscopy - _____ years

Allergies:

Your Medical History

Arthritis	Y / N
Asthma/COPD	Y / N
Atrial Fibrillation	Y / N
Breast Cancer	Y / N
Colon Polyps	Y / N
Diabetes Mellitus	Y / N
Heart Attack	Y / N
Hepatitis (Viral)	Y / N
Hypertension	Y / N
Irritable Bowel	Y / N
Pancreatitis	Y / N
Peptic Ulcer	Y / N
Prostate Radiation	Y / N
Stroke	Y / N
Thyroid Disease	Y / N

Your Surgical History

Appendectomy	Y / N
Gallbladder Surgery	Y / N
Heart Bypass	Y / N
Heart Defibrillator	Y / N
Hip Replacement	Y / N
Hysterectomy	Y / N
Pacemaker	Y / N
Prostate Surgery	Y / N
Stent in the Heart	Y / N
Other: _____	

Your Social History

Single / Married

Alcohol (circle) yes / no

Caffeine (circle) yes / no

Diet drinks (circle) yes / no

Tobacco (circle) yes / no

Occupation _____

Your Family History

Colon Cancer	Y / N
Ulcer Disease	Y / N
Liver Disease	Y / N
Gallbladder Disease	Y / N

Other _____

Review of Systems

Weight Loss: _____lbs	
Significant fever / chills	Y / N
Chronic / acute cough	Y / N
Chronic / acute wheezing	Y / N
Recent shortness of breath	Y / N
Recent chest pain/pressure	Y / N
Irregular heartbeat	Y / N
Blood clots in leg / lung	Y / N
Taking blood thinners	Y / N
Easy bruising	Y / N
Urine infection / bleeding	Y / N
Excess thirst/drinking water	Y / N
Acute joint swelling / pain	Y / N
Anxiety / depression	Y / N

Please Circle yes / no

Weight Loss	Y / N
If yes , how many pounds _____	
Loss of Appetite:	Y / N
Heartburn:	Y / N
Trouble Swallowing: Solids/liqui	Y / N
Nausea/Vomiting:	Y / N
If yes food / blood (circle)	
Abdominal Pain:	Y / N
Location - upper / lower	
Wakes you up at night	Y / N
Relieved by antacids/Zantac	Y / N
Take Aspirin / Advil etc	Y / N
Pain after eating greasy food	Y / N
Family Gallbladder Disease	Y / N
Change bowel movements:	Y / N
Diarrhea:	Y / N
How long? _____	
Recent Antibiotic	Y / N
Constipation:	Y / N
Use Laxatives Routinely	Y / N
How long? _____	Y / N
Black Bowel Movements:	Y / N
How long? _____	
Bloody Bowel Movements:	Y / N
How long? _____	

Other _____