Patient's Name:	DOB:	Today's Date:
Primary Physician:	Primary Physician Phone No:	Primary Physician Fax No:
Referring Physician:	Referring Physician Phone No:	Referring Physician Fax No:

Reason for your visit:
____
____
____

Current Medicines: (name and dose)

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

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):
Videocapsule 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 grandmother:
□ Stomach or esophagus cancer	Paternal grandfather:
□ Diabetes	Maternal grandmother:
□ Coronary artery disease	Maternal grandfather:

Personal Information:

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

Patient's Name: ____________________________________ Today's Date: ________________

Review of Systems:
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:
- □ ________________