

Centers for Gastroenterology
Patient Medical Information Sheet

Patient Name _____
Age _____

Date of Birth _____

Today's Date _____

Reason for visit _____

Past Medical History (Please mark all conditions which apply to you)

<input checked="" type="checkbox"/> Condition	Year
Gastrointestinal	XXX
<input type="checkbox"/> Barrett's Esophagus	
<input type="checkbox"/> Celiac Disease	
<input type="checkbox"/> Colon Cancer	
<input type="checkbox"/> Colon Polyps	
<input type="checkbox"/> Cirrhosis	
<input type="checkbox"/> Crohn's Disease	
<input type="checkbox"/> Diverticulitis	
<input type="checkbox"/> Diverticulosis	
<input type="checkbox"/> Esophageal Cancer	
<input type="checkbox"/> Esophageal Stricture	
<input type="checkbox"/> Heartburn/ GERD	
<input type="checkbox"/> Hepatitis B	
<input type="checkbox"/> Hepatitis C	
<input type="checkbox"/> Irritable Bowel Syndrome	
<input type="checkbox"/> Other liver disease	
<input type="checkbox"/> Pancreatitis	
<input type="checkbox"/> Ulcerative Colitis	
<input type="checkbox"/> Ulcer Disease	

<input checked="" type="checkbox"/> Condition	Year
Cardiac	XXXX
<input type="checkbox"/> Atrial Fibrillation	
<input type="checkbox"/> CongestiveHeartFailure	
<input type="checkbox"/> Heart Attack/CAD	
<input type="checkbox"/> Heart Murmur	
<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Stroke	
Pulmonary	XXXX
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Emphysema/COPD	
<input type="checkbox"/> Sleep Apnea	
<input type="checkbox"/> Tuberculosis	
Endocrine	XXXX
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Thyroid Disease	
HEENT	XXXX
<input type="checkbox"/> Glaucoma	

<input checked="" type="checkbox"/> Condition	Year
Bone/Joint	XXXX
<input type="checkbox"/> Joint Disease	
<input type="checkbox"/> Osteoporosis	
Gentourinary	XXXX
<input type="checkbox"/> Kidney Disease	
Neurological	
Seizure Disorder	
Immunology	XXXX
<input type="checkbox"/> HIV positive	
Psychiatric	
<input type="checkbox"/> Anxiety/Depression	
Hematology	XXXX
<input type="checkbox"/> Anemia	
<input type="checkbox"/> Bleeding disorder	
<input type="checkbox"/> Blood clots	
<input type="checkbox"/> Blood thinner use	

Personal – Past Surgical History (please mark all those which apply to you)

<input type="checkbox"/> Colon resection/surgery	
<input type="checkbox"/> Gallbladder removed	
<input type="checkbox"/> Heart surgery/Bypass	
<input type="checkbox"/> Heart valve replacement	
<input type="checkbox"/> Adhesion surgery	

<input type="checkbox"/> Appendectomy	
<input type="checkbox"/> Joint Replacement	
<input type="checkbox"/> Weight loss surgery	
<input type="checkbox"/> Esophagus surgery	
<input type="checkbox"/> Back/spine	

<input type="checkbox"/> Transplant Surgery	
<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Small bowel surgery	
<input type="checkbox"/> Mastectomy	
<input type="checkbox"/> Aortic Aneurysm	

Other Medical or Surgical conditions not mentioned above:

List any Laboratory tests performed last 6 months; List any X-rays in the last year : approx date and where performed

Past Endoscopic History

	Year	Year	Year	Year	Year	Year
Colonoscopy				ERCP		
Upper Endoscopy (EGD)						

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Medications

Please list all medications you are taking, including over the counter medications and supplements

Medications	Dosage	Frequency of Use
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Please list any allergies or reactions to medications

Social History

Marital Status	Single <input type="checkbox"/>	Married <input type="checkbox"/>	Other <input type="checkbox"/>
Do you have Children ? Y/N		Please list Number and ages :	

Occupation:

	Type	Amount	How often	# Years used	Last use (or "quit")
Tobacco Use <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> former					
Illicit Drug Use <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> former					
Alcohol Use <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> former					
Caffeine Use <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> former					

Family History of blood relatives:

History of Colon Cancer Y or N If Yes, Whom? _____ Age of onset _____
 History of Colon Polyps Y or N If Yes, Whom? _____ Age of onset _____

Please mark if **ANY RELATIVE** has had the following :

	Relative	Relative	Relative
<input type="checkbox"/> Celiac Disease		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Ovarian Cancer		<input type="checkbox"/> Breast Cancer	
<input type="checkbox"/> Uterine Cancer		<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Stomach Cancer		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Pancreatic Cancer		<input type="checkbox"/> Cardiovascular disease	
<input type="checkbox"/> Pancreatitis		<input type="checkbox"/> Ulcerative Colitis	
		<input type="checkbox"/> Gallstones	
		<input type="checkbox"/> Ulcers	
		<input type="checkbox"/> Crohn's disease	
		<input type="checkbox"/> Liver disease/cirrhosis	
		<input type="checkbox"/> Liver cancer	