Date of appointment: _____

Patient name: _____ Date of birth: _____ Age: _____

Primary care provider: _____ Referring provider: _____

Reason for Visit: _____

Nurse use only:

Preferred local pharmacy: _____ Preferred mail order pharmacy: _____

Preferred laboratory for blood work: _____ Preferred radiology facility: _____

HT _____ Weight _____ BP _____/_____ Pulse _____

Vaccines: Flu/When?_____ (65 or older) Pneumonia/When?_____

Fallen within the last 3 months? _____ Fear of falling?_____ Difficulty ambulating? _____

Patient Review of Systems

Please mark any condition with which you have had significant problems in the last 6 months:

Constitution
___ Chills
___ Diaphoresis (Night sweats)
___ Fatigue
___ Fever
___ ***Loss of appetite***
___ ***Weight loss***
___ ***Weight gain***

HEENT
___ Eye pain
___ Trouble swallowing
___ ***Yellow eyes***

Respiratory
___ Chronic cough
___ Shortness of breath
___ Wheezing
___ ***Excessive snoring***
___ ***Hoarseness***

Cardiovascular
___ Chest pain
___ Palpitations

Gastrointestinal
___ Abdominal distention (Bloating)
___ Abdominal pain
___ Blood in stool
___ Constipation
___ Diarrhea
___ Nausea
___ Vomiting
___ ***Black stool***
___ ***Change in bowel habits***
___ ***Difficulty swallowing***
___ ***Gas/flatulence***
___ ***Heartburn/indigestion***
___ ***Bowel accidents***
___ ***Reflux***
___ ***Vomiting blood***

Genitourinary
___ Pain on urination (Dysuria)
___ Flank pain
___ Blood in urine (Hematuria)

Musculoskeletal
___ Back pain
___ Arthralgia's (Joint pain)

Skin
___ Rash
___ Color changes (Yellow skin)

Neurological
___ Dizziness
___ Headaches
___ Light-headedness
___ Seizures
___ Weakness

Hematological
___ Enlarged lymph nodes (Adenopathy)
___ Bruises/bleeds easily

Psychiatric
___ Behavior problems (Depression)
___ Nervous/anxious
___ Sleep disturbances

Patient name: _____ Date of birth: _____

Immunizations:

	Y/N	Date last received
Flu Vaccine		
If 65 or older, Pneumococcal Vaccine		

Medications (please list if not attached):

Medication Name	Dose	Frequency

Medication Allergies:

Name of allergen	Reaction/Date of Onset

Patient Medical History

Please mark ALL conditions which apply to you, the year diagnosed, and any treatment received:

	Y	Year diagnosed & treatment received		Y	Year diagnosed & treatment received
Anemia			Myocardial infarction		
Anxiety			Nerve/muscle disease		
Arthritis			Osteoporosis		
Asthma			Seizures		
Blood transfusion			Stroke		
Cancer			Substance abuse		
Congestive Heart Failure (CHF)			Thyroid disease		
COPD			Tuberculosis		
Depression			***Atrial fibrillation***		
Diabetes mellitus			***Heart attack, CAD***		
Emphysema			***High cholesterol***		
Heart murmur			***Sleep apnea***		
HIV/AIDS			***Joint disease***		
Hypertension			***Bleeding disorder***		
Kidney disease			***Blood clots***		
			Other medical history not listed		

Patient name: _____ Date of birth: _____

Please mark ALL conditions which apply to you, the year diagnosed, and any treatment received:

	Y	Year diagnosed & Treatment received		Y	Year diagnosed & Treatment received
Celiac disease			Hernia		
Cholelithiasis (gall stones)			Irritable bowel syndrome		
Chronic constipation			Liver cancer		
Chronic diarrhea			Liver disease		
Cirrhosis of the liver			Pancreatic cancer		
Colon cancer			Pancreatitis		
Colon polyps			Peptic ulcer		
Crohn's disease			Rectal cancer		
Diverticulitis			Small intestine cancer		
Diverticulosis			Stomach cancer		
Esophageal cancer			Ulcerative colitis		
GERD/reflux disease			***Esophageal stricture***		
Hepatitis			***Ulcer disease***		
			Other GI medical history not listed		

Patient GI Surgical/Procedure History

Please mark ALL that apply with dates of GI surgeries/procedures:

Surgery/Procedure	Y	Date of surgery/ procedure	Surgery/Procedure	Y	Date of surgery/ procedure
Appendectomy			Liver biopsy		
Cholecystectomy (gallbladder removal)			Liver surgery		
Colon surgery/resection			Polypectomy		
Colonoscopy			Sigmoidoscopy		
Colostomy			Small bowel enteroscopy		
ERCP			Small intestine surgery		
Esophageal surgery			Stoma closure, large bowel		
EUE – Esophageal ultrasound with cryotherapy			Stomach surgery		
Gastric bypass			Upper GI endoscopy		
Gastric fundoplication					

Please mark ALL that apply and dates of any surgeries:

	Y	Date of surgery		Y	Date of surgery
Brain surgery			Prostate surgery		
Breast surgery			Back/Spine surgery		
Cosmetic surgery			Valve replacement		
Eye surgery			Vasectomy		
Fracture surgery			***Aortic Aneurysm***		
Heart surgery			***Hysterectomy***		
Hernia repair			***Mastectomy***		
Joint replacement			***Transplant surgery***		

Patient name: _____ Date of birth: _____

Family History

Family history of colon cancer, please list maternal or paternal blood relative if applicable:

	Y/N	If yes, whom	Age of onset
History of colon cancer			
History of colon polyps			

Indicate if any blood relative has the following. (Please note which relative and if it's maternal or paternal)

	Relative		Relative		Relative
Breast cancer		**Gallstones**		**Stomach cancer**	
Cardiovascular disease		**Hypertension**		**Stroke**	
Celiac disease		**Liver cancer**		**Ulcers**	
Crohn's disease		**Ovarian cancer**		**Ulcerative colitis**	
Cirrhosis/liver disease		**Pancreatic cancer**		**Uterine cancer**	
Diabetes		**Pancreatitis**			

Social History

Tobacco Use: Y/N/Former Packs/day: _____ Quit date: _____

Smokeless Tobacco: Y/N/Former Type: Chew/Snuff Quit date: _____

Alcohol use: Y/N/Former

Drinks per week: ____ glasses of wine ____ cans of beer ____ shots of liquor

Drug use: Y/N/Former

Types: ____ marijuana ____ methamphetamine ____ cocaine ____ IV

Other:

_____

_____

Caffeine use: Y/N/Former Amount/Day: _____ Type: _____

Marital Status: _____ **Occupation:** _____

Children Y/N: _____ **How many children:** _____

Other

Other GI surgical or procedure history not listed:

_____

_____

Please list any lab or radiology testing performed within the last 6 months and where they were performed:

_____

_____