

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Referred by: \_\_\_\_\_ Referred for: \_\_\_\_\_

PCP if not the referring M.D.: \_\_\_\_\_ Other MD's: \_\_\_\_\_

**Social History:**

Occupation \_\_\_\_\_

Do you have a family member that is seen in this office?  No  Yes, who? \_\_\_\_\_

**Have you ever seen a doctor that treats the stomach, colon, liver, gallbladder, bile ducts or pancreas?**

Yes  No

Name/Date: \_\_\_\_\_ Name/Date: \_\_\_\_\_

(For Office Use Only)

B/P: \_\_\_\_\_ T: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ O<sup>2</sup> Sat: \_\_\_\_\_ Weight: \_\_\_\_\_

\_\_\_\_\_ Height: \_\_\_\_\_

\_\_\_\_\_ BMI: \_\_\_\_\_

**Are you experiencing any of the following symptoms? (Please check)**

Persistent cough (One which has lasted for 3 or more weeks)  Bloody Sputum  Night Sweats  
 Weight loss  Anorexia  Fever

**Are you experiencing any of the following upper GI symptoms? (Please check)**

Painful swallowing  Vomiting blood  Indigestion  Excessive belching  
 Food sticking  Reflux  Abdominal pain \_\_\_\_\_  
 Nausea  Heartburn  Weight loss  
 Vomiting  Loss of appetite  Early satiety (fill up too quickly)

**Are you experiencing any of the following lower GI symptoms? (Please check)**

Diarrhea  Black, tarry stool  Rectal pain  
 Constipation  Urgency  Incontinence (soiling)  
 Red blood in stool  Hemorrhoids  Gas/bloating  
 Straining  Rectal prolapse

**Elimination Habits:**

Number of bowel movements per day \_\_\_\_\_, per week \_\_\_\_\_.

Bowel movements are (please circle): hard, soft, formed, loose, watery, marble-like

Do you see pus or mucous in stool?  Yes  No

**Personal Habits:**

	Current	Past History
Daily tobacco use:	_____	_____ (Packs/how much snuff/chewing tobacco/cigars per day)
Alcohol use:	_____	_____ (drinks per day/week)
Daily caffeine use:	_____	_____ (cups or glasses of Coke, coffee or tea a day)
Dairy products:	_____	_____ (how many servings per day)
Herbal remedies:	_____	_____ (how much/how many times a day or week)

**Have you ever had any of the following x-rays of the stomach and/or colon (please check)**

		Where/Doctor who ordered	Results	Date
(approx)				
Barium enema:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Upper GI:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Small bowel:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Ultrasound of gallbladder:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
CT of abdomen:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Hida Scan:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Gastric emptying scan:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
MRI of the abdomen:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____

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**LABORATORY WORK:**

Have you had any recent lab work done?  Yes  No When: \_\_\_\_\_ Where: \_\_\_\_\_  
Have you had a recent EKG?  Yes  No When: \_\_\_\_\_ Where: \_\_\_\_\_

**Have you ever had your throat, stomach or intestines looked at with a lighted scope? (Please check)**

	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where/Doctor	Date (Approx)
Panendoscopy (stomach)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Colonoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Flexible sigmoidoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
ERCP	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Stretching of your esophagus	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

**Medical History: (please check)**

ANESTHESIA – Have you ever had trouble with it?.....	<input type="checkbox"/> Yes, what? _____	<input type="checkbox"/> No
COMPLICATIONS – Have you ever had any after procedures/surgery?	<input type="checkbox"/> Yes, what? _____	<input type="checkbox"/> No
Breathing problems / COPD/ Emphysema/ Asthma/ Sleep Apnea.....	<input type="checkbox"/> Yes (circle problems)	<input type="checkbox"/> No
Diabetes .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High blood pressure / TIA / Stroke .....	<input type="checkbox"/> Yes (circle problems)	<input type="checkbox"/> No
Heart disease/heart attack/heart surgery .....	<input type="checkbox"/> Yes (circle problems)	<input type="checkbox"/> No
Mitral valve prolapse .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you take antibiotics before dental or other procedures? .....	<input type="checkbox"/> Yes, why? _____	<input type="checkbox"/> No
Glaucoma .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizures .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis/yellow jaundice .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of hip or knee joint replacement .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any pins or screws in your body .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any recent antibiotic use .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ever been treated for H. pylori bacteria .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any cancer .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood transfusions (if “yes”, when _____) .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any recent stress .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any emotional problems (depression, panic attacks, etc.) .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any history of alcohol or drug abuse .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to pain management? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you taking any diet pills? .....	<input type="checkbox"/> Yes, what? _____	<input type="checkbox"/> No

**Other Conditions:**

\_\_\_\_\_  
\_\_\_\_\_

Are you pregnant? \_\_\_\_\_ Are you nursing? \_\_\_\_\_

Have you ever had chemotherapy or radiation therapy?  Yes  No

**Surgical History:**

Surgery:	Findings	Date/Place:	Surgeon:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Family History: (Any stomach/colon/liver problems; polyps, Crohn’s, Ulcerative colitis; Breast/ovarian/colon cancer)**

\_\_\_\_\_  
\_\_\_\_\_

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**CURRENT:**

**Medications You Are Now Taking (including any over the counter medications, hormones and birth control pills):**

Drug/Mg/Frequency

Drug/Mg/Frequency

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**PAST:**

**Have you ever used any of the following medications on a regular basis? (If 'YES', when, and did it work?)**

Aspirin containing medications (Goodies, Excedrin, Aspirin, Alka-Selzer) Yes No \_\_\_\_\_

Arthritis Medications (Nsaid, Motrin, Ibuprofen, Advil, Aleve, etc.) Yes No

Ulcer medications (Prilosec, Prevacid, Aciphex, Tagamet, Protonix, Nexium) Yes No \_\_\_\_\_

Stomach cramps medication (Librax, Levsin, Donnatal, Hyoscyamine, Bentyl NuLev, Zelnorm) Yes No \_\_\_\_\_

Nerve Pills (Xanax, Valium, Tranxene, Prozac, Zoloft, Paxil, etc.) Yes No \_\_\_\_\_

Blood thinners (Coumadin, Aspirin, Heparin, etc.) Yes No \_\_\_\_\_

Anti Nausea medicines (Phenergan, Zofran, Compazine) Yes No \_\_\_\_\_

Iron tablets Yes No \_\_\_\_\_

Laxatives (Correctol, Senokot, Lactulose, Miralax, Kristalose, etc.) Yes No \_\_\_\_\_

Herbal Product: \_\_\_\_\_ Yes No \_\_\_\_\_  
Please specify product

Medication to help stomach empty faster ( Reglan, Propulsid, etc.) Yes No \_\_\_\_\_

Fiber supplements (Metamucil, Fiber-Con, Citrucel, Konsyl, Equalactin) Yes No \_\_\_\_\_

Diet pills (Prescription or over-the-counter) \_\_\_\_\_ Yes No \_\_\_\_\_  
Please specify product

Antacids (Tums, Rolaids, etc.) Yes No \_\_\_\_\_

Questran powder, Cholestid, Welchol Yes No \_\_\_\_\_

Imodium, Lomotil or Pepto Bismol (for diarrhea) Yes No \_\_\_\_\_

Asacol, Pentasa, Prednisone, Imuran, Purinethol, Methotrexate, Remicade Yes No \_\_\_\_\_

Accutane Yes No \_\_\_\_\_

List pain medications you've used in the past  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies (Including medications, x-ray dye, latex, tapes, foods, etc.):**

_____	_____	_____	_____
_____	_____	_____	_____

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_