Consultants In Gastroenterology, PA

Name: _____ Date: _____

I. Chief Complaint

What is your primary reason for this visit?

_____

Seen at the request of?

_____

Have you had any previous tests, x-rays or labs?

_____

II. Past Medical History

Do you have or ever had:

Yes	No		Yes	No	
☐	☐	High blood pressure	☐	☐	Anemia
☐	☐	Diabetes	☐	☐	Colon cancer
☐	☐	Heart disease	☐	☐	Colon polyps
☐	☐	Lung disease	☐	☐	Other cancers
☐	☐	Kidney disease	☐	☐	Joint replacements
☐	☐	Gallstones	☐	☐	Rheumatic fever
☐	☐	Peptic ulcer	☐	☐	Artificial heart valve
☐	☐	Intestinal problems	☐	☐	Psychiatric illness
☐	☐	Thyroid disease	☐	☐	Blood transfusion
☐	☐	Pancreatitis	☐	☐	Bleeding problem
☐	☐	Hemorrhoids	☐	☐	Asthma

If yes, please explain: _____

_____

III. Current Medications

Please list all prescription and nonprescription medications.

_____

_____

_____

IV. Drug Allergies

☐ None

_____

_____

V. Social History

Yes	No	
☐	☐	Do you drink alcohol? If yes, how much? _____
☐	☐	Do you smoke cigarettes? If yes, how much? _____ If you quit, when? _____
☐	☐	Do you drink caffeinated beverages? If yes, what? _____ How much? _____
☐	☐	Are you in a high-risk group for contracting HIV or the AIDS virus? *If you don't know, please ask.*

VI. Family History (Parents, Siblings, Children)

Has anyone in your immediate family ever had:

Yes	No		Yes	No	
☐	☐	Colon cancer	☐	☐	Liver disease
☐	☐	Other cancers	☐	☐	Cirrhosis
☐	☐	Peptic ulcer	☐	☐	Kidney disease
☐	☐	High blood pressure	☐	☐	Gallstones
☐	☐	Diabetes	☐	☐	Psychiatric illness
☐	☐	Heart disease	☐	☐	Lung disease
☐	☐	Other digestive disease	☐	☐	Thyroid disease

VII. Digestive System

Yes	No	
☐	☐	Loss of weight
☐	☐	Loss of appetite
☐	☐	Excessive fatigue
☐	☐	Increased stress
☐	☐	Frequent nausea
☐	☐	Vomiting
☐	☐	Vomiting blood
☐	☐	Difficulty swallowing
☐	☐	Frequent indigestion
☐	☐	Heartburn
☐	☐	Awaken at night with pain
☐	☐	Abdominal pain
☐	☐	With eating does stomach fill up faster
☐	☐	Change in size, shape or color of stool
☐	☐	Frequent diarrhea
☐	☐	Frequent constipation
☐	☐	Blood associated with bowel movements
☐	☐	Black/tarry stools
☐	☐	Pain with meals
☐	☐	Jaundice
☐	☐	Do you take laxatives?
☐	☐	Do you take antacids?

VIII. Do you occasionally or frequently have: (more than six times a year);

Yes	No	
☐	☐	Visible abdominal bloating
☐	☐	Incomplete emptying of the bowels
☐	☐	Mucus in the stool
☐	☐	Abdominal cramping prior to bowel movements
☐	☐	Relief of pain with bowel movements
☐	☐	Abdominal pain related to more frequent, loose bowel movements

IX. Previous Hospitalizations or Surgery

Date	Reason