***Please answer the following questions as accurately as possible. Your past medical history and your family history are used to determine what your insurance will cover for procedures. Inaccurate information can affect how your claim is paid. Please sign and date after answering the questions.**

PATIENT HISTORY FORM

NAME ______________________________ DATE ____________________

AGE ____________ REFERRING DOCTOR ______________________________

MAIN COMPLAINT - THE MAIN REASON YOU ARE SEEING THE DOCTOR TODAY: *Check Only One*

_____ Abnormal Liver Tests
_____ Bloating
_____ Blood in Stool
_____ Change In Bowel Habits
_____ Constipation
_____ Diarrhea
_____ Difficulty Swallowing
_____ Fever
_____ GERD-Heartburn-Indigestion
_____ Hepatitis
_____ Lower Abdominal Pain
_____ Nausea
_____ Painful Swallowing
_____ Positive Stool Cards
_____ Upper Abdominal Pain
_____ Weight Loss
_____ Vomiting

Other ______________________________

OTHER SYMPTOMS YOU ARE HAVING: PLEASE CIRCLE YES OR NO

Bloating	Yes - No	Diarrhea	Yes - No	Nausea	Yes - No
Blood in Stool	Yes - No	Difficulty Swallowing	Yes - No	Painful Swallowing	Yes - No
Change in Bowel Habits	Yes - No	Fever	Yes - No	Upper Abdominal Pain	Yes - No
Constipation	Yes - No	Lower Abdominal Pain	Yes - No	Weight Loss	Yes - No

Other ______________________________

What specific concerns or questions would you like the physician to address? (Fear of cancer, hepatitis, etc.)

____

REVIEW OF SYSTEMS - IF YOU ARE CURRENTLY EXPERIENCING: PLEASE CIRCLE YES OR NO

CONSTITUTIONAL

Fatigue	Yes - No
Fever	Yes - No
Loss of Appetite	Yes - No
Night Sweats	Yes - No
Rigors	Yes - No
Weight Loss	Yes - No
Weight Gain	Yes - No

Other ______________________________

EARS-NOSE-MOUTH-THROAT

Bad Breath	Yes - No
Ears Ringing	Yes - No
Hearing Loss	Yes - No
Hoarseness	Yes - No
Post Nasal Drip	Yes - No
Sore Throat	Yes - No
Difficulty Swallowing	Yes - No

Other ______________________________

RESPIRATORY

Cough	Yes - No
Shortness of Breath	Yes - No
Wheezing	Yes - No

Other ______________________________

CARDIOVASCULAR

Chest Pain	Yes - No
Edema	Yes - No
Palpitation	

Other ______________________________

GENITOURINARY

Blood in Urine	Yes - No
Difficulty Starting Urine Stream	Yes - No
Frequent Urination	Yes - No
Painful Urination	Yes - No
Dark urine	Yes - No

Other ______________________________

MUSCULOSKELETAL

Back pain	Yes - No
Joint Pain	Yes - No
Morning Stiffness	Yes - No
Raynaud's	Yes - No

Other ______________________________

INTEGUMENTARY

Itching	Yes - No
Rash	Yes - No

Other ______________________________

PSYCHIATRIC

Anxiety Disorder	Yes - No
Depression	Yes - No
Panic Attack	Yes - No
Sleep Disorder	Yes - No

Other ______________________________

ENDOCRINE

Change In Hair Pattern	Yes - No
Dry Skin	Yes - No
Heat/Cold Intolerance	Yes - No

Other ______________________________

HEMATOLOGIC / LYMPHATIC

Anemia	Yes - No
Bleeding / Bruising Tendency	Yes - No
Enlarged Lymph Nodes	Yes - No
Sickle Cell trait	Yes - No

Other ______________________________

GENERAL MEDICAL HISTORY

Dialysis	Yes or No	Heart Valve Replacement	Yes or No	Dementia	Yes or No
Kidney Disease	Yes or No	Mitral Valve Prolapse	Yes or No	Epilepsy	Yes or No
Heart Attack	Yes or No	Congestive Heart Failure	Yes or No	Seizers	Yes or No
Diabetes	Yes or No	Deliberator	Yes or No	Stroke	Yes or No
Heart Disease	Yes or No	Pacemaker	Yes or No	Multiple Sclerosis	Yes or No
Atrial Fibrillation	Yes or No	Heart Stents	Yes or No		
High Blood Pressure	Yes or No	if yes, date placed: ____________			

PAST GASTROENTEROLOGY MEDICAL HISTORY (check all that apply).

- o Barrett's Esophagus
- o GERD (acid reflux)
- o Stomach Ulcer
- o H pylori
- o Trouble swallowing
- o Stomach cancer
- o Delayed gastric emptying
- o Hiatal hernia
- o Gallstones
- o Hepatitis (type) _________
- o Cirrhosis
- o Primary biliary cirrhosis
- o Fatty liver
- o Abnormal liver tests
- o Pancreatitis
- o Celiac disease
- o Colon polyp history
- o Colon cancer
- o Diverticulitis
- o Diverticulosis
- o Irritable bowel disease
- o Crohn's disease
- o Ulcerative colitis

DIAGNOSTIC STUDIES/TEST (Check a that apply)

RADIOLOGY	DATE:
o Ultrasound of Abdomen	____________
o HIDA Scan	____________
o MRCP	____________
o ERCP	____________

RADIOLOGY:	DATE:
o Barium Enema	____________
o CT of the abdomen/Pelvis	____________
o MRI of the abdomen/Pelvis	____________
o Small bowel series	____________

PROCEDURE:	DATE:
o Colonoscopy	____________
o Endoscopy (EGD)	____________
o Pill Endoscopy	____________
o Bravo PH test	____________

PROCEDURE:	DATE:
o Esophageal dilation	____________
o Esophageal manometry	____________
o Liver biopsy	____________

SURGICAL HISTORY (Check all that apply)

SURGERY:	DATE:
o Gallbladder removed	____________
o Whipple procedure	____________
o Appendectomy	____________
o Reflux surgery	____________
o Hiatal hernia repair	____________
o Gastric bypass	____________

SURGERY	DATE:
o Gastric lap band	____________
o Exploratory laparotomy	____________
o Colectomy-partial	____________
o Total colectomy	____________
o Small bowel resection	____________
o Colostomy	____________

SURGERY	DATE
o Mastectomy	____________
o Bladder suspension	____________
o Prostate surgery	____________
o Coronary artery bypass graft	____________
o Hysterectomy	____________
o Total hip replacement	____________

Do you have Sleep Apnea? Yes or No

Do you use a C-Pap Machine? Yes or No

Have you ever experienced an adverser reaction (low blood pressure/heart rate, difficulty breathing, etc.) to intravenous sedation or anesthesia? Yes or No

If yes, what procedure/operation____________________________________ Date of procedure: __________________________

SOCIAL HISTORY (Circle ALL that apply.)

Do you smoke? Yes or No If yes for how long _______ and how much: _______

How long ago did you quit: _____

Do you drink alcohol? Yes or No If yes, for how long _____ Type: Wine, Beer, Liquor. How may ____ How often ________

Do you use drugs? Yes or No If yes, for how long _____ Type ____

Do you drink caffeine? Yes or No If yes, what type: Coffee, Soda, Tea.

How much: 1 cup, 1-2 cups, 3 or more cups. How often: 1 time a day 2 times a day 3 or more times a day

Do you exercise? Yes or No What type: Running Walking Biking Yoga Cardio Weights

FAMILY HISTORY (circle ALL that apply)

Colon Cancer	Father	Mother	Paternal Grandparent	Maternal Grandparent	Paternal Aunt/Uncle	Maternal Aunt/Uncle	Brother	Sister
Colon Polyps	Father	Mother	Paternal Grandparent	Maternal Grandparent	Paternal Aunt/Uncle	Maternal Aunt/Uncle	Brother	Sister
Ulcerative Colitis/Crohn's	Father	Mother	Paternal Grandparent	Maternal Grandparent	Paternal Aunt/Uncle	Maternal Aunt/Uncle	Brother	Sister
Liver Disease	Father	Mother	Paternal Grandparent	Maternal Grandparent	Paternal Aunt/Uncle	Maternal Aunt/Uncle	Brother	Sister
Celiac Disease	Father	Mother	Paternal Grandparent	Maternal Grandparent	Paternal Aunt/Uncle	Maternal Aunt/Uncle	Brother	Sister

Other cancers ____

Allergies | **Reaction**

Allergies to Latex? Yes/No

If Yes, please describe: ______________________________

Pharmacy name: ______________________________

Address: ______________________________

City,St,Zip: ______________________________

Phone: ______________________________

Current Medications:
(Including over-the-counter medicines such as aspirin, Tylenol, vitamins, herbs, supplements, etc.)

Name	Dose/How often	Reason

I hereby adhere that the above information is true and to the best of my knowledge.

Signature: ______________________________ Date: ______________________________

Information provided by:

Patient   Spouse   Caretaker/Provider

FOR OFFICE USE ONLY:

Reviewed by: ______________________________ Front Office

Reviewed by: ______________________________ Medical Staff