Gastrointestinal Specialists

PART I TO BE COMPLETED BY PATIENT

Date: _____ Phone: _____

Name: _____ Date of Birth: _____

Reason for Visit: _____

PLEASE CHECK IF YOU OR A FAMILY MEMBER HAS HAD ANY OF THE FOLLOWING ILLNESSES:

(If a family member, please indicate father, mother, sister, etc., under "who")

	Who		Who
☐ Ulcerative Colitis	_____	☐ Celiac Sprue	_____
☐ Ulcer Disease	_____	☐ Liver Disease	_____
☐ Colonic Polyps	_____	☐ Crohn's Disease	_____
☐ Colonic Carcinoma	_____		

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE EXPERIENCED DURING THE LAST YEAR:

☐ Weight Loss	☐ Abdominal Pain	☐ Insomnia
☐ Weight Gain	☐ Diarrhea	☐ Lump in Breast
☐ Change in Vision	☐ Constipation	☐ Nipple Discharge
☐ Change in Hearing	☐ Blood in Stool	☐ Menstrual Problems
☐ Gum or Mouth Pain	☐ Urination Difficulty	☐ Headache
☐ Fainting	☐ Numbness	☐ Weakness
☐ Seizures	☐ Tremor	☐ Back Pain
☐ Skin Changes	☐ Joint Pain / Swelling	☐ Wheezing
☐ Hoarseness	☐ Difficulty Breathing	☐ Fever / Chills
☐ Cough	☐ Night Sweats	☐ Lightheadedness
☐ Chest Pain / Tightness	☐ Palpitations	☐ Tension
☐ Leg Swelling / Pain	☐ Increased Thirst	☐ Depression

Do you smoke?	☐ Yes	☐ No	If yes, how much: _____
Do you use alcohol?	☐ Yes	☐ No	If yes, how much: _____
Do you use drugs?	☐ Yes	☐ No	_____
Do you drink coffee or tea?	☐ Yes	☐ No	If yes, how much: _____

What is your occupation? _____

_____
(Patient Signature)

PART II (TO BE COMPLETED BY THE NURSE)

Please list all current medications (prescription and non-prescription):

NAME OF MEDICATION	DOSE	HOW OFTEN YOU TAKE	PURPOSE

Allergies: Drug: _____

PAST HISTORY

Medical illnesses: _____

Hospitalizations: _____

Medical: _____

Surgical: _____

FAMILY HISTORY

Father: _____ Mother: _____

Brothers: _____ Sisters: _____

Nurse's Signature: _____