Center for Gastroenterology & Nutrition

Date:_____ **DOB:**_____ **Age:** _____ **SEX:** M/F **PCP:**_____

Reason for Visit:_____

Allergies to Medications:_____

History of the Present Illness:

Where is the pain/problem?_____

How often does it occur?_____

When did it begin?_____

What triggers or triggered the problem?_____

What makes your pain/problem better or worse?_____

Describe the pain/problem:_____

How would you describe the severity of the pain/problem: Mild__ Moderate__ Severe__

Family History

Blood Relatives	Age if Living	Age at Death	Major Illnesses and/or Cause of Death
Mother			
Grandmother			
Grandfather			
Father			
Grandmother			
Grandfather			
Brothers #__			
Sisters #__			
Children #__			

Habits *Do you or have you used any of the following?*

Tobacco □ Never □ Now □ Quit (year)_____ Type used □ cigarettes □ cigars □ pipe □smoleless

Alcohol □ Never □ Social/Rare □ Now □ Quit (year)____

Drug Use □ Never □ Now □ Quit (year)____

Caffeine □ Coffee cups per day □ Tea cups per day

Exercise □ None □ Now_____ times per week

Nutrition *Do you follow any special diet or have any dietary restrictions?* _____

Immunizations □ Hepatitis A □ Hepatitis B □Pneumovax □Zostavax

Screening Exams □ Colonoscopy yr_____ □ DEXA Scan yr____

Values/Belief Assessment *Do you have?*

□ Donor card □ Living Will □ Durable Power or Attorney for Health Care

Do you have religious or cultural practices we should be aware of? □ No □ Yes

Health care information can be shared with the following individuals:

_____

Previous Procedures □ None

□ Angioplasty □ Appendectomy □ C-Section □ Cardiac Surgery □ Gallbladder Surgery

When: _____ When:_____ When:____ When:_____ When:_____

□ Colon Resection □ Coronary Artery Bypass Surgery □ Gastric Band □ Gastric Bypass

When:_____ When:_____ When:_____ When:_____

□ Hernia Repair □ Hysterectomy □ Pacemaker/Defibrillator □ Small Bowel Resection

When:_____ When:_____ When:_____ When:_____

Review of Systems

General: □ Weight loss □ Weight gain □Fever □ Night sweats □ Fatigue □ Weakness □ Pain

Skin: □ Rashes □ Dryness □ Hair loss □ Hives □ Itching□ Previous positive skin test for TB
Eyes:□Pain □ Excessive tearing □ Dryness □ Redness□ Blurred vision □ Double vision □ Yellow

□ Light sensitivity □ Cataracts

Ears: □ Pain □Ringing□ Hearing loss

Nose: □ Nosebleeds □ Post nasal drip □ Sinus pain

Mouth: □ Gum soreness □ Gum bleeding □ Tongue pain □ Altered taste

Throat: □ Hoarseness □ Trouble swallowing (solids, liquifs, or both) □ Painful swallowing

Lungs: □ Shortness of breath □ Cough □ Coughing blood □Wheezing□ Asthma □ Apnea

□ Previous BCG vaccine

Heart and Circulation :□ Chest pain or tightness □ Fast or slow or irregular heart beat

□ Ankle swelling □ Low blood pressure □ High blood pressure □ Previous blood clot

□ Previous heart attack □ Previous stroke

Urinary: □Frequent urination □ Burning with urination □ Blood in the urine □ Kidney stones

Gastrointestinal: □ Nausea □ Vomiting □ Vomiting blood □ Change in bowel habits □ Diarrhea

□ Constipation □ Blood in stool □ Indigestion □ Belching □ Bloating □Abdominal pain

□ Gallbladder problems □ Stomach ulcer □Liver problems □ Colon polyps□ Diverticulitis

□ Lactose intolerance

Muscle, Joints, and Bones: □ Joint pain □ Joint swelling □ Muscle pain □ Muscle weakness

□ Bone pain □ Bone fractures

Nervous System: □ Seizures □ Tremors □ Headaches □ Paralysis

Hormones: □ Heat or cold intolerance

Blood: □ Anemia □ Easy bruising or bleeding

Psychological: □ Depression □ Difficulty sleeping

Genitals (Males only): □ Sores □ Penile discharge □ Hernia □ Testicular pain □ Erection difficulty

Genitals (Females only): □ Sores □ Vaginal discharge □ Irregular periods □ Painful intercourse