Gastroenterology Evaluation Form

Name: _____ DOB: _____ Sex: M F Date: _____

Referring Doctor: _____ Primary Care Provider: _____

Cardiologist: _____ Other Providers: _____

Medical History (Please check all that apply)

□ High Blood Pressure	□ Emphysema	□ Heart Attack	□ Shortness of Breath
□ Kidney Disease	□ Abnormal Heart Rhythm	□ Diabetes	□ Arthritis
□ Chest Pain	□ Stroke	□ Migraines	□ Asthma
□ Kidney Stones	□ Seizures	□ Tuberculosis	□ COPD
□ Depression	□ Sleep Apnea	□ Blood Clots	□ Blood Disorder
□ Glaucoma	□ HIV/AIDS	□ Cancer(s): _____	

□ Other: _____

Last Mammogram: _____ Last Pap-smear: _____

Vaccination/ Immunization

Vaccination/ Immunization	Date of vaccination/ immunization (MM/YYYY)	Did not receive immunization (Mark X here)
Last Influenza- flu shot		
Hepatitis B		
Pneumococcal- pneumonia shot		
Shingles/ Zoster		
Last Tuberculosis (TB) Skin Test		

Surgeries

□ Tonsils and Adenoids	□ Hysterectomy	□ Hernia Repair	□ Appendix
□ Joint Replacement	□ Hemorrhoid	□ Gallbladder	□ Heart
□ Pancreas	□ Thyroid	□ Colon Resection	□ Breast
□ Organ Transplant	□ Nissen Fundoplication	□ Pacemaker	□ Defibrillator

□ Other: _____

Allergy List

Medication, Environmental, and/or Food	Reaction

Family Medical History

(Please enter one of the following in the blank space: F= Father, M=Mother, B=Brother, S=Sister, C=Child)

____ Colon Polyps	____ Esophageal Cancer	____ Irritable Bowel Syndrome
____ Colon Cancer	____ Stomach Cancer	____ Esophageal Reflux
____ Colitis	____ Gallbladder Disease	____ Pancreatitis
____ Crohn's Disease	____ Breast Cancer	____ Pancreatic Cancer
____ Liver Disease	____ Stomach Ulcers	____ Prostate Cancer
____ Blood Disorders	Other: _____	

Social History

Tobacco

□ Current every day smoker □ Current some day smoker □ Former smoker □ Never smoker

□ Cigarettes □ Chew □ Cigars Packs per day _____ How many years _____ Year quit _____

Alcohol Use

□ No □ Never □ Previous □ Current □ History of alcoholism

How often? □ Rare □ Socially □ Regularly □ Heavy Type: □ Beer □ Liquor □ Wine

Illicit Drug Use

□ Never □ Current □ Previous Years Sober: _____

□Marijuana □ Cocaine □ Heroin □ Methamphetamine □ Other: _____

Work History

□ Full-time □ Part-time □ Homemaker □ Disabled □ Retired □ Student

Living Situation

□ Alone □ Lives with family □ Spouse □ Other: _____

Exercise

□ Never □ Rarely □ Occasionally □ Regularly- timer per week: _____

Exposures

□ Tattoos, if so how many? _____ □ Blood Transfusion, if so how many? _____

Diet

□ High Fiber □ Low Fiber □ Vegetarian □ Vegan □ Caffeine Use, if yes how much _____

Use of NSAIDS

□ Aspirin □ Advil □ Aleve □ Goody's □ Ibuprofen □ Naproxen □ Excedrin

Review of Systems (current symptoms)

General:□ Fever □ Chills □ Fatigue □ Decreased Appetite □ Weight Loss □ Weight Gain

Psychiatric: □ Depression □ Anxiety □ Stress

Skin: □ Rash □ Skin Change □ Itchiness □ Jaundice

Eyes: □ Jaundice □ Glaucoma

Ears: □ Ear Pain □ Hearing Loss □ Ringing of Ears □ Ear Fullness □ Ear Drainage

Nose: □ Nasal Congestion □ Nose Bleeds

Head: □ Headaches □ Sinus Headache □ Sinus Infection

Eyes: □ Glaucoma □ Cataracts

Mouth/Throat:□ Dentures □ Dry Mouth □ Mouth Ulcers □ Hoarseness □ Trouble Swallowing □ Painful Swallowing

Respiratory: □ Shortness of Breath □ Wheezing □ Cough □ Trouble Breathing □ Sleep Apnea

Cardiovascular: □ Chest Pain □ Palpitations □ Congestive Heart Failure □ Murmur □ Heart Attack □ Angina

Gastrointestinal: □ Seen other GI Doctor(s) □ Ulcerative Colitis □ Crohn's Disease □ Abdominal pain □ Heartburn

□ Reflux □ Belching □ Gas □ Bloating □ Nausea □ Vomiting □ Difficulty Swallowing □ Painful Swallowing

□ Diarrhea □ Constipation □ Blood in Stool □ Black Stools □ Change in bowel habits □ Mucus in Stool

□ Pain with Bowel Movement □ Straining During Bowel Movement □ Urgency with Stools □ Stooling Accidents

□ Rectal Pain □ Hemorrhoids □ Colon Polyps □ Diverticulitis □ Change in Stool Caliber

Genitourinary: □ Frequent Urination □ Incontinence □ Blood in Urine □ Heavy Periods

□ History of Bladder/Kidney Infections □ History of Kidney Stones

Neurological: □ Dizziness □ Headaches □ Fainting □ History of Stroke □ Seizures

Musculoskeletal: □ Arthritis □ Osteoporosis □ Fractures □ Joint Pain □ Muscle Pain

Endocrine: □ Thyroid Problems □ Diabetes □ Hormone Imbalance □ Heat Intolerance □ Cold Intolerance

Hematologic/Lymph: □ Excessive Bruising □ Excessive Bleeding □ History of Blood Transfusion

□ History of Anemia □ Blood Thinner

Immunologic: □ Food Allergies □ Frequent Infections □ Frequent Steroid Use □ Problems with Immunity

Scope History (Please check all that you have had in the past)

□ Colonoscopy, if so what year was it done? _____ By whom? _____

□ EGD (Upper Endoscopy) □ ERCP □ EUS (Endoscopic Ultrasound)

Have you ever had issues with anesthesia? □ No □ Yes, please explain: _____

Medication List

Name of Medication	Dose (mg, mcg, units)	Times Taken Per Day, Week, Month, or Year

Patient Name: ______________________________ **DOB:** ______________