

Gastroenterology Evaluation Form

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

Referring Doctor: _____ Primary Care Provider: _____

Cardiologist: _____ Other Providers: _____

Vaccination/ Immunization

Vaccination/ Immunization	Date of vaccination/ immunization (MM/YYYY)	Did not receive immunization (Mark X here)
Last Influenza- flu shot		
Pneumococcal- pneumonia shot		

Allergy List

Medication, Environmental, and/or Food	Reaction
Reaction to Anesthesia: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type of reaction: _____	

Medical History (Please check all that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Abnormal Heart Rhythm | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Migraines | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Seizures | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Blood Disorder |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Cancer(s): _____ | |
| <input type="checkbox"/> Other: _____ | | | |

Surgeries

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Tonsils and Adenoids | <input type="checkbox"/> Hysterectomy (Year: ____) | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Appendix |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Hemorrhoid | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Heart |
| <input type="checkbox"/> Pancreas | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Colon Resection (Year: ____) | <input type="checkbox"/> Breast (Year: ____) |
| <input type="checkbox"/> Nissen Fundoplication | <input type="checkbox"/> Pacemaker (Year: ____) | <input type="checkbox"/> Defibrillator (Year: ____) | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Cardiac Stent (Year: ____) | <input type="checkbox"/> Abdominal Surgeries: _____ | | |
| <input type="checkbox"/> Other: _____ | | | |

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

- Colonoscopy, year was it done? _____ By whom? _____
- EGD (Upper Endoscopy) ERCP EUS (Endoscopic Ultrasound)

Preventive

Last Mammogram (month & year): _____ Last Pap-smear (month & year): _____

Social History

Tobacco

- Current everyday 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

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: _____

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

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

Respiratory: Shortness of Breath Wheezing Cough Home Oxygen 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

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

Patient Name: _____ **DOB:** _____

