

Gastroenterology & Hepatology New Patient Intake Form

Today's Date _____

Name _____

Date of Birth _____

Marital Status Married Single Widowed Divorced Other _____

Gender Male Female

EMPLOYMENT

Employer / Occupation _____

PERSONAL HISTORY

Describe the reason(s) for your visit _____

Referred to Gastroenterology by _____ Primary Care Physician _____

Other physicians involved in your care _____

Provide details regarding current and/or past use of the following:

Alcohol (beer, wine, liquor) Yes No Weekly Consumption _____

Tobacco (cigarettes, cigar, chewing tobacco) Yes No Usage/Frequency _____

IV or Recreation Drugs Yes No Usage/Frequency _____

Recent colonoscopy/EGD? Yes No Where? _____

Recent Imaging? (CT, XRAY, U/S) Yes No Where? _____

Recent labs? Yes No Where? _____

PATIENT MEDICAL HISTORY (check all that apply)

- | | | | | |
|--|---|--|---|---|
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hepatitis C (HCV) | <input type="checkbox"/> Stroke | <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Irritable Bowel Syndrome (IBS) | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> End Stage Renal Disease (ESRD) | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Obesity | <input type="checkbox"/> Stomach/Intestinal Ulcers | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pancreatitis | | |
| <input type="checkbox"/> GERD/reflux | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart Disease/Attack | |

Other past medical history not listed:

PAST SURGICAL HISTORY

FAMILY HISTORY	Mother	Father	Siblings	Son	Daughter	Grandmother	Grandfather
Barrett's Esophagus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer							
Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Esophagus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease/Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheat Allergy (Celiac)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SYSTEM REVIEW

Do you have or have you experienced any of the following in the last **6 months?**

GASTROINTESTINAL <input type="checkbox"/> Abdominal Pain/Discomfort <input type="checkbox"/> Anal/Rectal Pain or Itching <input type="checkbox"/> Black Stool <input type="checkbox"/> Bloating/Belching/Gas <input type="checkbox"/> Change of Bowel Habits <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea/Loose Stool <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Heartburn/reflux <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Mucus in Stool <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Pain w/ Bowel Movements <input type="checkbox"/> Rectal Bleeding	CARDIOVASCULAR <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Racing/Skipping <input type="checkbox"/> Palpitations	GENITOURINARY <input type="checkbox"/> Are you pregnant? <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Recent Urinary Tract Infection	NEUROLOGIC <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness/Vertigo <input type="checkbox"/> Head Trauma/Injury <input type="checkbox"/> Recent Numbness/Weak
	RESPIRATORY <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing or Asthma	SKIN / EYES / MOUTH <input type="checkbox"/> Itching/Dry Skin <input type="checkbox"/> Jaundice (yellow eyes or skin) <input type="checkbox"/> Visual Changes <input type="checkbox"/> Mouth Ulcers/Sores	CONSTITUTIONAL <input type="checkbox"/> Fatigue <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Night Sweats <input type="checkbox"/> Weight Loss
	MUSCULOSKELETAL <input type="checkbox"/> Back Pain <input type="checkbox"/> Joint Pain/Arthritis	HEMATOLOGY / LYMPHATIC <input type="checkbox"/> Bleeding Problems <input type="checkbox"/> Excessive Bruising <input type="checkbox"/> History of Anemia	PSYCHIATRY <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression