

Gastroenterology Associates

Gastroenterology and Hepatology

**(PLEASE COMPLETE BOTH SIDES)
(PRINT)**

Doctor: _____

Date: _____

Name: _____ Age: _____

Referred By: _____

Birthdate: _____

Occupation: _____

Marital Status: _____

The chief problem relating to the digestive system has been _____

Approximate date of onset: _____

Have you been having any of the following symptoms:

No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite? For how long? _____
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing (food sticking)? For how long? _____
<input type="checkbox"/>	<input type="checkbox"/>	Pain on swallowing? For how long? _____
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn? For how long? _____
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers? For how long? _____
<input type="checkbox"/>	<input type="checkbox"/>	Regurgitation of food or fluid? For how long? _____
<input type="checkbox"/>	<input type="checkbox"/>	Recurring vomiting spells? For how long? _____
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain or distress? For how long? _____
<input type="checkbox"/>	<input type="checkbox"/>	Does eating aggravate the pain?
<input type="checkbox"/>	<input type="checkbox"/>	Does eating relieve the pain?
<input type="checkbox"/>	<input type="checkbox"/>	Is the pain related to position or activity
		Walking <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Lying Down <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Is pain aggravated by bowel movements?
<input type="checkbox"/>	<input type="checkbox"/>	Is pain relieved by bowel movements?
		How frequently do you have bowel movements? _____
<input type="checkbox"/>	<input type="checkbox"/>	Constipation? For how long? _____
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea? For how long? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you seen blood in the stools? For how long? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had hemorrhoids or rectal pain? For how long? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do stools appear greasy or oily? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you regularly take a laxative? Which one? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a parasitic infection (ameba, worms)?
		If so, which kind? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had jaundice? Is so, when? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had liver or gallbladder problems?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a pancreas problem?
		What is your present weight? _____ One year ago? _____
		Are there foods which regularly aggravate your digestive distress?
		If so, please list them _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you follow a specific dietary program? If so, what kind and who placed you on it?

		What is your usual coffee consumption? _____
		What is your usual alcohol consumption? _____
		What is your usual milk or dairy consumption? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke? If so, how much? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you take aspirin or aspirin-containing medications? _____
		If so, which ones and how often? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you take antacids?
		If so, which ones and how often? _____

Have you had previous gastrointestinal X-rays?

Gallbladder: _____
(date) (where taken)

Upper GI Series: _____

(date) (where taken)

Barium Enema: _____

(date) (where taken)

Have you had any operations?

Type and Reason	Year	Hospital	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any of the following?

<input type="checkbox"/> No	<input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Pain or pressure in the chest
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular problems
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or bladder trouble
<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness, fainting	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash
<input type="checkbox"/>	<input type="checkbox"/>	Visual impairment	<input type="checkbox"/>	<input type="checkbox"/>	Backache or other joint or muscle complaints
<input type="checkbox"/>	<input type="checkbox"/>	Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	Feeling of sadness, depression, or hopelessness
<input type="checkbox"/>	<input type="checkbox"/>	Sinus complaints			

Family History

	Age	Major Health Problems	Age at Death	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother	_____	_____	_____	_____
Or	_____	_____	_____	_____
Sister	_____	_____	_____	_____
	_____	_____	_____	_____

Current Medications:

Allergies: _____

<p>FOR WOMEN ONLY: Age menstruation started? _____ Are periods regular? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Heavy _____ Medium _____ Light _____ Date of last period? _____ Pain or cramps? _____ Vaginal discharge? _____ Do you see a Gynecologist regularly? If so, whom? _____</p>
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Office use:

