GASTROINTESTINAL SPECIALISTS OF GEORGIA, P.C.

Patient History Form

Patient Name:______________________________Age:__________ Date:__________________________________

Primary Care Physician:______________________________ Referred by:________________________________

Race/Ethnicity (Medicare required):_______________________ Height:______________ Weight:______________

Allergies:(Please completely fill in circles or write in others)

O None O Latex O Iodine O Penicillin O Sulfa

O Others (please list):____

CURRENT SYMPTOMS/ILLNESSES (Please fill in circles completely)

Symptom			Symptom		
Heartburn	OY	O N	Bloody stools	OY	O N
Trouble swallowing	OY	O N	Weight loss	OY	O N
Painful swallowing	OY	O N	Lack of appetite	OY	O N
Nausea	OY	O N	Anemia	OY	O N
Vomiting	OY	O N	Hepatitis	OY	O N
Abdominal Pain	OY	O N	Jaundice	OY	O N
Bloating, Distention, Excess gas	OY	O N	Liver problems	OY	O N
Constipation	OY	O N	Gallbladder problems	OY	O N
Diarrhea	OY	O N	Pancreas problems	OY	O N
Change in bowel habits	OY	O N	Crohn's or Ulcerative colitis	OY	O N

Other:____

____

MEDICAL HISTORY (Please fill in circles completely and write in additional comments)

Condition			*Year & comment*	Condition			*Year & comment*
History of colon cancer	OY	O N		Irritable Bowel Syndrome	OY	O N	
History of colon polyps	OY	O N		Hypertension	OY	O N	
Reflux disease	OY	O N		Heart attack	OY	O N	
Barrett's esophagus	OY	O N		Heart disease	OY	O N	
Crohn's disease	OY	O N		Stroke	OY	O N	
Ulcerative Colitis	OY	O N		High cholesterol	OY	O N	
Anemia	OY	O N		Lung disease	OY	O N	
Hepatitis A	OY	O N		Diabetes	OY	O N	
Hepatitis B	OY	O N		Cancer history	OY	O N	
Hepatitis C	OY	O N		Psychiatric disorder	OY	O N	
Other Liver disease	OY	O N		Arthritis	OY	O N	
				Thyroid disease	OY	O N	

Please list any others:

____

PAST SURGICAL HISTORY (Please fill in circles completely and write in addition comments)

			Year & comment				Year & comment
Appendectomy	OY	O N	______	Coronary stent placed	OY	O N	______
Gallbladder surgery	OY	O N	______	Heart bypass surgery	OY	O N	______
Stomach surgery	OY	O N	______	Heart valve surgery	OY	O N	______
Colon surgery	OY	O N	______	Breast surgery	OY	O N	______
Other intestinal surgery	OY	O N	______	Hysterectomy	OY	O N	______
Hemorrhoidectomy	OY	O N	______	Ovaries removed	OY	O N	______
Hernia repair	OY	O N	______	Thyroid surgery	OY	O N	______

Other Surgeries:

____

____

MEDICATIONS:

Are you on any of these medications? (Please fill in circles completely)

O Aspirin
O Plavix/other blood thinners
O Arthritis medications
O Ibuprofen products
O Coumadin/Warfarin
O Insulin

Please list all your medications and dosages (or provide a separate list if you prefer):

______________________ ______________________

______________________ ______________________

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______________________ ______________________

______________________ ______________________

FAMILY HISTORY: (Fill in ALL that apply and write in age at diagnosis)

	Father	Mother	Sibling	Child	Grandparent	Other	Age(s) at diagnosis
Colon Cancer	O	O	O	O	O	O	______
Colon Polyps	O	O	O	O	O	O	______
Stomach Cancer	O	O	O	O	O	O	______
Pancreatic Cancer	O	O	O	O	O	O	______
Celiac Disease	O	O	O	O	O	O	______
Ulcerative Colitis	O	O	O	O	O	O	______
Crohn’s Disease	O	O	O	O	O	O	______
Liver Disease	O	O	O	O	O	O	______
Gallbladder Disease	O	O	O	O	O	O	______
Heart Disease	O	O	O	O	O	O	______
Other Cancers	O	O	O	O	O	O	______

List other significant diagnoses:______________________________

Were you adopted? O YES O NO

SOCIAL HISTORY (Please fill in a circle for each section)

Alcohol use:	Tobacco use:	Illicit Drug use:	Other: (fill in ALL that apply)
O None	O None	O Never	O Tattoo
O <1 drink/day	O Less than ½ pack/day	O Past experimentation	O Blood transfusion
O 1-2 drinks/day	O 1 pack/day	O Former use	
O 3-5 drinks/day	O More than 1 pack/day	O Recent/Active use	
O 6 or more drinks/day	O Former tobacco use	Type of drug: ____________	
O Former alcohol use			

Married: O Y O N

Children: O Y O N If yes, # of Kids: ______

Occupation: ____________________________

Review of Systems: Fill in ALL of the following you have experienced over the last year **OR** fill in None

HEENT:	O None	O Nosebleeds	O Sinus/Postnasal drip	O ringing in ears	O sore throat
DERM:	O None	O skin rash	O skin itching	O skin sores	O hair loss
OPTHO:	O None	O vision change	O eye pain/redness	O double vision	O jaundice
DENTAL:	O None	O oral ulcers	O bleeding gums	O hoarseness	O bad breath
PULM:	O None	O Chronic cough	O shortness of breath	O asthma/wheezing	O cough up blood
CARDIAC:	O None	O Chest pain	O irregular heart beat	O rapid heart rate	O palpitations
URINARY:	O None	O bloody urine	O frequent urination	O difficulty urinating	O painful urination
GYN:	O None	O pelvic pain	O heavy vaginal bleeding	O abnormal discharge	O irregular menses
MUSC/SKEL:	O None	O leg cramps	O pain with movement	O muscle/joint pains	O low back pain
NEURO:	O None	O seizures	O numbness/weakness	O fainting/dizziness	O headaches
HEME:	O None	O bruise easily	O genetic bleeding disorder	O blood clots history	O excess bleeding
ENDO:	O None	O weight loss	O heat/cold intolerance	O excessive thirst	O excess urination
PSYCH:	O None	O panic attacks	O anxiety all the time	O inability to think	O inability to sleep
OTHER:	O None	O pregnant	O complications of surgery	O latex allergy	O egg/soy allergy
	O sleep apnea	O anesthesia complication	O Home oxygen	O glaucoma	

Patient Signature: ______________________________ Date: ______________

Physician Signature: ______________________________ Date: ______________

Anesthesia Signature: ______________________________ Date: ______________

Staff Signature: ______________________________ Date: ______________