

ALBANY GASTROENTEROLOGY CONSULTANTS

Welcome to our practice. Please help us to serve you better by completing this form as best as you can.

Name:		Date:
Age:	DOB:	Sex:
Marital Status: M S D W	Occupation:	
Referring Doctor:		
Advanced Directive: Yes _____ No _____		
If yes, please explain:	1) DNR _____	2) Living Will _____
	3) Healthcare Proxy _____	4) Medical POA _____

Why are you here?

In general, would you say your health is:

- Excellent
 Very Good
 Good
 Fair
 Poor

Gastrointestinal Symptoms:

Please check if you have or had the following gastrointestinal symptoms.

- | | | |
|---|---|---|
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Yellow eyes / jaundice | <input type="checkbox"/> Black / tarry stools |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Rectal bleeding |
| <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Pain after meals | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Bloating | <input type="checkbox"/> Fissures |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Constipation | <input type="checkbox"/> Anal pain |

Past Medical History:

Please check if you have or had the following medical problems.

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Tattoos |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> IV drug use |
| <input type="checkbox"/> Colon cancer | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> HIV (AIDS) |
| <input type="checkbox"/> Colon polyps | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diverticular disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney failure |
| <input type="checkbox"/> Ulcerative colitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bladder infection |
| <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Other _____ |

Past Surgeries and Procedures:

Please check if you had the following surgeries (with dates if possible).

- | | |
|---|---|
| <input type="checkbox"/> Stomach or bowel surgery | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Organ transplant |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hysterectomy | _____ |
| <input type="checkbox"/> Angioplasty | _____ |
| <input type="checkbox"/> Bypass surgery | _____ |

Hospitalization and Tests: Please check if you had the following:

Procedure	Date	Where
<input type="checkbox"/> Recent hospitalization		
<input type="checkbox"/> Recent blood tests		
<input type="checkbox"/> Upper endoscopy		
<input type="checkbox"/> Colonoscopy		
<input type="checkbox"/> ERCP		
<input type="checkbox"/> H. pylori test		
<input type="checkbox"/> Abdominal untrasound		
<input type="checkbox"/> CT		
<input type="checkbox"/> MRI		

Current Medication List: Check if you are taking any of the following then write other current medications (including over the counter drugs) with doses and duration of use.

<input type="checkbox"/> Anti-inflammatory medicines	<u>Medicine</u>	<u>Dose</u>	<u>Frequency</u>
<input type="checkbox"/> Aspirin containing medicines	_____	_____	_____
<input type="checkbox"/> Coumadin, heparin	_____	_____	_____
<input type="checkbox"/> Narcotic or sedative medications	_____	_____	_____
<u>Medicine</u>	<u>Dose</u>	<u>Frequency</u>	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

Allergies: Check the drugs you have allergies to:

- | | | | |
|--------------------------------------|---|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Demerol / Fentanyl | <input type="checkbox"/> Iodine dye | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Valium / Versed | <input type="checkbox"/> Latex | <input type="checkbox"/> _____ |

What type of reaction did you have to above medications?: _____

Are you advised to have antibiotics before (dental) procedures? Yes / No

Any problems with anesthesia or sedation for prior procedures? Yes / No

Family Medical History:

Mother: Alive Deceased Age: _____ Medical problems: _____

Father: Alive Deceased Age: _____ Medical problems: _____

Children: Alive Deceased Age: _____ Medical problems: _____

Siblings: Alive Deceased Age: _____ Medical problems: _____

Check and list family member with age at diagnosis.

- | | | |
|--|--|--|
| <input type="checkbox"/> Colon polyps | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Colon cancer | <input type="checkbox"/> Colitis/Crohn's | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Stomach cancer | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Pancreas cancer | <input type="checkbox"/> Strokes | <input type="checkbox"/> Breast cancer |

Social History:

Exercise not at all 1-3 times a week 4-7 times a week

Alcohol None _____ drinks per week

Cigarettes None _____ packs per day

Coffee/tea None _____ cups per day

Soda None _____ cups per day

Recreational drug use None _____

Review of Systems:

Please check if you have or had the following problems:

General	<input type="checkbox"/> Weight loss or gain _____ lbs.	<input type="checkbox"/> Night sweats
	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Recent travel out of the country
	<input type="checkbox"/> Fever or chills	
Head, eyes, ears, nose and throat	<input type="checkbox"/> Severe headaches	<input type="checkbox"/> Hearing problems
	<input type="checkbox"/> Vision problems	<input type="checkbox"/> Hoarseness
	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Dentures
	<input type="checkbox"/> Nose / sinus problems	<input type="checkbox"/> Canker sores
Cardiovascular	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Heart murmur
	<input type="checkbox"/> Leg pain with walking	<input type="checkbox"/> Heart racing/palpitations
	<input type="checkbox"/> Dizziness or fainting spells	<input type="checkbox"/> Feet or ankle swelling
	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Waking-up short of breath
Respiratory	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Persistent cough
	<input type="checkbox"/> Asthma	<input type="checkbox"/> Sputum production
	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Bloody sputum
	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Wheezing
Endocrine	<input type="checkbox"/> Increased thirst	<input type="checkbox"/> Easy fatigue
	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Increased urination
Hematology	<input type="checkbox"/> Anemia or low blood counts	<input type="checkbox"/> Frequent nose bleeds
	<input type="checkbox"/> Swollen glands	
Genitourinary	<input type="checkbox"/> Penile/Vaginal discharge	<input type="checkbox"/> Blood in urine
	<input type="checkbox"/> Pain with urination	<input type="checkbox"/> Trouble starting urinary stream
	<input type="checkbox"/> Kidney infections	<input type="checkbox"/> Genital warts
		<input type="checkbox"/> Sexually transmitted disease
Neuromuscular	<input type="checkbox"/> Joint or muscle ache/swelling	<input type="checkbox"/> Numbness
	<input type="checkbox"/> Memory difficulty	<input type="checkbox"/> Dizziness
	<input type="checkbox"/> Temporary blindness	<input type="checkbox"/> Tingling of hand and feet
	<input type="checkbox"/> Speaking difficulty	<input type="checkbox"/> Migraines
Psychiatry	<input type="checkbox"/> Depression	<input type="checkbox"/> Sleep disturbance
	<input type="checkbox"/> Suicidal thoughts	<input type="checkbox"/> Anxiety
	<input type="checkbox"/> Hearing voices	<input type="checkbox"/> Eating disorder
Skin	<input type="checkbox"/> Skin rash	<input type="checkbox"/> Hives
Breasts	<input type="checkbox"/> Breast lumps or swelling	<input type="checkbox"/> Nipple discharge
	<input type="checkbox"/> Breast pain	
Women	Number of pregnancies: _____	Last day of period: _____
	<input type="checkbox"/> Birth control	Last Pap smear: _____
	<input type="checkbox"/> Menopause	Last mammography: _____

To be filled out by office staff:

Exam:

Wt:

BP:

P:

R:

Physician Signature: _____

Date: _____