Digestive Disease Physicians

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Office Use Only:

Height: ________

Weight: ______

BP: _____/_____

Pulse: ________

Temp: ________F

Patient Clinical Forms

Name: ____ Date of birth: ____________________

Best Contact #: ___________________________________ Can we leave a message: □ yes or □ no

Primary Care Provider: ____________________________ Referring Provider: ____

Preferred Language (circle one): English Spanish Other, please specify: _______________________________

Occupation: ____

Chief Complaint: ____

Personal Medical History

Diagnosed GI Conditions

□ Alcohol Abuse	□ Constipation	□ Disorder of gallbladder	□ GERD	□ Hepatitis B	□ Irritable Bowel Syndrome
□ Anal Fissure	□ C-Diff infection	□ Diverticulitis	□ H pylori	□ Hepatitis C	□ Pancreatitis
□ Barrett's esophagus	□ Colon polyps	□ Esophageal stricture	□ Liver failure	□ Hemorrhoids	□ Peptic Ulcer Disease
□ Celiac disease	□ Crohn's disease	□ GI bleeding	□ Hepatitis A	□ Hiatal Hernia	□ Ulcerative colitis
					□ Difficulty Swallowing

Other: ____

Other Medical History

□ Anemia	□ Cardiac Stent placement	□ Heart disease	□ Osteoporosis
□ Atrial Fibrillation	□ Congestive Heart Failure	□ High cholesterol	□ Seizure disorder
□ AICD	□ COPD	□ High blood pressure	□ Sleep apnea
□ Anxiety	□ Depression	□ HIV	□ Stroke
□ Arthritis	□ Diabetes	□ Kidney Disease	
□ Asthma	□ Fibromyalgia	□ Lupus	□ Cancer:
□ Blood clots	□ Heart attack	□ Multiple Sclerosis	□ Thyroid Disease

Other: ____

Surgical History (please list dates) (year)

□ Appendix Removed	□ Gallbladder Removed	□ Hernia Repair	Other: ___________________
□ Artificial Joints	□ Heart Surgery	□ Hysterectomy	________________________
□ Cesarean Section	□ Hemorrhoids	□ Pacemaker/Defibrillator	________________________
□ Colon Surgery	□ Hernia Repair		

Current Medications

Please list all prescription, over the counter, herbals, vitamins and supplements you currently take:

Name: ____ **DOB:** _________________________________

Allergies (Drug, Food Anesthesia)

Please list below. If none, please check here □

DRUG	REACTION

Social History

Tobacco Use:
□ Never Smoker
□ Former Smoker
□ Current every day smoker – packs per day: ________

Alcohol Use:
□ None
□ Yes – how much? ___________

Marital Status:
□ Single
□ Married
□ Divorced
□ Widow

Family History

The Following Family Members Should Be Considered: Mother/Father, Brothers/Sisters, Children, Aunts/Uncles, Grandparents

		Relation
Colon Cancer	□ No □ Yes	________________
Colon polyps	□ No □ Yes	________________
Ovarian Cancer	□ No □ Yes	________________
Uterine Caner	□ No □ Yes	________________
Gastric Cancer	□ No □ Yes	________________
Pancreatic Cancer	□ No □ Yes	________________

		Relation
Celiac Disease	□ No □ Yes	________________
Crohn's Disease	□ No □ Yes	________________
Liver Disease/Hepatitis	□ No □ Yes	________________
Ulcerative Colitis	□ No □ Yes	________________
Esophageal Cancer	□ No □ Yes	________________
Lynch Syndrome	□ No □ Yes	________________

Preferred Pharmacy (Name, Location, Telephone number):

____

For Women Only

Are you still menstruating? _____________

Date of start of last menstrual period: _____ / _____ / _____

Are you currently pregnant? _____________

Recent Diagnostic Study/Imaging/Labs (please list with date)

____

____

Other: ____