

# SOUTHWEST GASTROENTEROLOGY ASSOCIATES, P.C.

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Diplomates of the American Board of Internal Medicine in Gastroenterology

## History

Name \_\_\_\_\_ Referring Physician \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Date of Visit \_\_\_\_\_

### Chief Complaint (Main Reason for Visit)

- |   |   |
|---|---|
| <input type="checkbox"/> Abdominal pain                 | <input type="checkbox"/> Heartburn/Indigestion                            |
| <input type="checkbox"/> Abnormal X-Ray or Imaging exam | <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Abnormal liver enzymes         | <input type="checkbox"/> Nausea or vomiting                               |
| <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Swallowing difficulty                            |
| <input type="checkbox"/> Blood in stool                 | <input type="checkbox"/> Weight loss/poor appetite                        |
| <input type="checkbox"/> Colon screening                | <input type="checkbox"/> Other not listed _____                           |
| <input type="checkbox"/> Constipation                   | _____   |
| <input type="checkbox"/> Diarrhea                       | _____   |
| <input type="checkbox"/> Change in Bowel Habits         |   |

### History of Present Illness

**Patient Notes** (Please describe the nature of your problem in the space below. Include things like how long you have noticed the problem, is it steady or does it come and go, does it occur day or night, or before or after meals. Where is the symptom located, where does it go and what does it feel like? Is it sharp, burning, cramping, dull, full etc? What makes it better and what makes it worse? Rate severity (1 mildest - 10 most severe) and whether it is improving or worsening over time. What other symptoms do you associate with your main problem?)

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Previous testing or treatments for this problem \_\_\_\_\_

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**Personal Medical History**

<b>Surgery:</b>	<b>Details</b>	<b>Date / Hospital</b>
<input type="checkbox"/> Appendectomy	_____	_____
<input type="checkbox"/> Breast	_____	_____
<input type="checkbox"/> Gallbladder	_____	_____
<input type="checkbox"/> Hernia repair	_____	_____
<input type="checkbox"/> Hysterectomy/ovaries	_____	_____
<input type="checkbox"/> Other intestinal/abdominal	_____	_____
<input type="checkbox"/> Tonsillectomy	_____	_____
<input type="checkbox"/> Stomach/duodenal ulcer	_____	_____
<input type="checkbox"/> Surgery not listed above	_____	_____
	_____	_____
	_____	_____

<b>Hospitalizations other than Surgery</b>	<b>Date / Hospital</b>
_____	_____
_____	_____
_____	_____

**Current Medical Problems**

- Arthritis \_\_\_\_\_
  - Asthma \_\_\_\_\_
  - Atrial fibrillation/ other heart rhythm disturbance \_\_\_\_\_
  
  - Anxiety/Depression \_\_\_\_\_
  - Chronic bronchitis/emphysema \_\_\_\_\_
  - Congestive Heart Failure \_\_\_\_\_
  - Coronary artery disease/angina \_\_\_\_\_
  - Diabetes mellitus \_\_\_\_\_
  - High blood pressure \_\_\_\_\_
  - High cholesterol/triglycerides \_\_\_\_\_
  - Kidney failure \_\_\_\_\_
  - Osteoporosis/osteopenia \_\_\_\_\_
  - Sleep apnea \_\_\_\_\_
  - Thyroid problems \_\_\_\_\_
  
  - Other \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Medications:** (Include over the counter and herbal products)

<b>Name</b>	<b>Dose /Frequency</b>	<b>Condition Being Treated / Duration</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Allergies to Medications:** (Include latex/tape, iodine and serious adverse reactions other than allergy)

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Social History**

Tobacco       No     Yes     Quit / when \_\_\_\_\_    Packs per day \_\_\_\_\_    # Years \_\_\_\_\_  
Alcohol       No     Yes     Quit / when \_\_\_\_\_    Drinks per wk \_\_\_\_\_    # Years \_\_\_\_\_  
Recreational Drug Use     No     Yes     Quit / when \_\_\_\_\_     Used needles    Drugs used \_\_\_\_\_  
Diet             vegetarian     lactose-free     caffeine-free     diabetic     regular     other \_\_\_\_\_  
Marital Status       Married       Single       Divorced       Widow/Widower  
Occupation \_\_\_\_\_

**Family History:** (include age of diagnosis in affected family member)

	Father	Mother	Brother/Sister	Other/ Other Generations
Colon cancer	_____	_____	_____	_____
Colon polyp	_____	_____	_____	_____
Esophageal cancer	_____	_____	_____	_____
Uterine/ovarian cancer	_____	_____	_____	_____
Stomach/small bowel cancer	_____	_____	_____	_____
Renal/ureteral cancer	_____	_____	_____	_____
Breast cancer	_____	_____	_____	_____
Liver disease	_____	_____	_____	_____
Gallbladder disease	_____	_____	_____	_____
Colitis/Crohn's disease	_____	_____	_____	_____
Other	_____	_____	_____	_____

**Review of Systems** (check if you have any of the following and describe further in space below)

**Gastrointestinal**

<input type="checkbox"/> Y <input type="checkbox"/> N Heartburn/regurgitation	<input type="checkbox"/> Y <input type="checkbox"/> N Bloating/gas	<input type="checkbox"/> Y <input type="checkbox"/> N Intolerance to other foods
<input type="checkbox"/> Y <input type="checkbox"/> N Difficulty swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N Incomplete evacuation of bowels	<input type="checkbox"/> Y <input type="checkbox"/> N Jaundice
<input type="checkbox"/> Y <input type="checkbox"/> N Painful swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N Symptoms improve with evacuation	<input type="checkbox"/> Y <input type="checkbox"/> N Gallstones
<input type="checkbox"/> Y <input type="checkbox"/> N Filling up quickly at meals	<input type="checkbox"/> Y <input type="checkbox"/> N Blood in stool or on toilet paper	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis A, B, C, other
<input type="checkbox"/> Y <input type="checkbox"/> N Nausea or vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N Mucus in stool	<input type="checkbox"/> Y <input type="checkbox"/> N Cirrhosis
<input type="checkbox"/> Y <input type="checkbox"/> N Abdominal pain	<input type="checkbox"/> Y <input type="checkbox"/> N Loss of control of bowels	<input type="checkbox"/> Y <input type="checkbox"/> N Fluid in abdomen (ascites)

Y  N Irregular bowel habits

Y  N Intolerance to milk

Y  N Pancreatitis

**General**

- Y  N Decreased appetite
- Y  N Unexpected weight loss
- Y  N Unexpected weight gain
- Y  N Fatigue
- Y  N Fever or chills

**Skin**

- Y  N Rash
- Y  N Itching
- Y  N Unusual hair loss

**ENT**

- Y  N Hearing loss/ringing
- Y  N Sore throat/hoarseness
- Y  N Sinusitis/Sinus drainage

**Eyes**

- Y  N Blind field of vision

- Y  N Cataracts

**Respiratory/Lung**

- Y  N Sleep apnea / CPAP mask
- Y  N Respiratory complications with sedation
- Y  N Chronic bronchitis/emphysema
- Y  N Difficulty breathing
- Y  N Persistent cough
- Y  N Asthma

**Cardiovascular**

- Y  N Chest pain, pressure, angina
- Y  N Coronary artery disease
- Y  N High blood pressure
- Y  N Swelling in feet or legs
- Y  N Abnormal heart rhythm

**Renal/Urinary/Kidney**

- Y  N Renal failure/insufficiency
- Y  N Electrolyte disturbances
- Y  N Kidney stones
- Y  N Difficulty with urination
- Y  N Urinary tract infections
- Y  N Prostate cancer/enlarged

**Endocrine**

- Y  N Diabetes
- Y  N Thyroid disease
- Y  N Osteoporosis/osteopenia

**Gynecology**

- Y  N Pregnant now?
- Y  N Endometriosis
- Y  N Heavy periods

**Musculoskeletal**

- Y  N Joint pain/arthritis
- Y  N Back / neck pain
- Y  N Muscle aching/weakness

**Neurologic**

- Y  N Headaches
- Y  N Strokes/ CVA
- Y  N Seizures

**Psychiatric**

- Y  N Depression
- Y  N Anxiety
- Y  N Suicide attempt
- Y  N Swollen/tender lymph node

**Blood / Lymph**

- Y  N Anemia
- Y  N Bruise easily
- Y  N Past blood transfusion

Other information not included above: \_\_\_\_\_

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\_\_\_\_\_  
Signature, Patient, or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewing Physician Signature

\_\_\_\_\_  
Date