Piedmont HealthCare
Gastroenterology & Hepatology

**Name:** _____ **DOB:** _____ **Date:** _____

**What health issues are we addressing today?**
_____
_____
_____
_____
_____

Preferred Pharmacy: _____

Primary Care Physician:
_____

**Please CIRCLE all that apply to you:**

**GENERAL:** *Fatigue *Malaise (lack of good health) *Poor Appetite *Weight Loss *Fever *Chills

**HEAD:** *Headaches *Migraines *Head trauma

**EYES:** *Refractive disorders**:*** *do you wear glasses or contacts for correction?*
*Cataracts:Cataract surgery *Macular Degeneration *Glaucoma *Diabetic eye problems

**EAR/NOSE/THROAT:** *Ringing in ears * Hearing loss * recent ear infections (otitis media)
*recent sinus infection (Sinusitis: Acute) *History of sinus problems (Sinuitis: Chronic)
*Sore Throat *Trouble Swallowing

**LUNGS:** *History of emphysema * COPD *Pneumonia *Bronchitis *Asthma
* Recent cough * Shortness of breath

**HEART:** *Hypertension: Taking medications?_____ *Valvular heart disease *Bypass surgery
*High cholesterol (Hyperlipidemia): Taking medications?_____
*Heart rhythm problems: atrial fibrillation, pacemaker and/or defibrillator
*Coronary artery disease: coumadin anticoagulant therapy *Angioplasty (year____)
*Stent placement (year_____) *Mitral Valve Prolapse

**GENITOURINARY:** *Recent Urinary tract infection *Kidney stones *recent blood in urine
*Prostate problems *Prostate cancer

**MUSCULOSKELETAL:** *Rheumatoid arthritis *Osteoarthritis: *Date of last bone density* _____
*Osteoporosis: *on medication?*_____ *Degenerative spine disease
*Fibromyalgia * take chronic pain medicines?_____

**NEUROLOGIC:** *History of carpal tunnel *Stroke * Mini Stroke (TIA) *Seizures
***Sleep apnea: _____ have a CPAP machine?_____** *Peripheral neuropathy

**PSYCHIATRIC:** *History of depression *Hospitalization for depression *Situational depression
*Nerve or anxiety problems:*under psychiatric care:Taking medications for depression/anxiety*

**SKIN:** *Skin cancers: *Basil cell/squamous cell/melanoma* *History of psoriasis *Current rash

**HEMATOLOGIC:** ***History of anemia * Easy bruising *Easy bleeding: *History of transfusions*

**GASTROINTESTINAL:** *Abdominal pain *belching * bloating * black/tarry stools * constipation * diarrhea * IBS
*Crohn's * ulcerative colitis * rectal bleeding * difficulty swallowing * heartburn/GERD
*nausea * vomiting

**ENDOCRINE:** *Thyroid disease: *Taking medications for thyroid disease*
*Diabetes mellitus > Type 1 or Type 2: *Oral medications: Insulin? If so, how long?* _____

**ALLERGY/IMMUNOLOGIC:** *Immune Deficiency?

**ALLERGIES**: *Allergic Rhinitis: *Environmental: Seasonal or Both*

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**What pharmacy do you use?** _____ **Location:** _____

## Current Medications *(prescription and over the counter)*

List **ALL** medications ***and*** circle those that are **NEW** to you within the last **four** months:

| | | |
|---|---|---|
| 1) | 5) | 9) |
| 2) | 6) | 10) |
| 3) | 7) | 11) |
| 4) | 8) | 12) |

**Who is your Primary Care Physician?** _____

Are you currently a patient of a Pain Clinic? ☐ Yes/No if yes: name and location_____

Do you take *blood thinners*? [ Yes/No

**CIRCLE** any of these you currently are taking:

* Aspirin * Plavix * Aleve * Ibuprofen * Coumadin * NSAIDs * Goody Powders
* Other: _____

Do you take *sleep medicines?* Yes/No ☐ **CIRCLE** any of these you currently are taking:

* Ambien * Lunesta * Restori * Trazodone
* Remeron * Risperdal

Do you take medications for depression or anxiety? Yes/No ☐ if yes, what? _____

Do you have allergies to any medications? Yes/No

If yes, please list the medication & **reaction;**

_____
_____
_____
_____

Do you take vitamins or supplements? Yes/No

Please list:

_____
_____
_____
_____

Do you have any **NON-**Medication allergies? Please list name and reaction: _____
_____
_____

## Patient Social History

**Marital Status:** ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed Occupation:_____

**Use of alcohol:** ❑ Never ❑ Rarely ❑ Moderate ❑ Daily how many?_____

**Use of tobacco:** ❑ Never ❑ Previously but quit ❑ Current packs per day _____

**Use of Drugs:** ❑ Never ❑ Type/Frequency_____

## Family Medical History

| | **AGE** | **Serious Health Conditions:** | **If Deceased, Cause of death** |
|---|---|---|---|
| Father: | | | |
| Mother: | | | |
| Siblings: | | | |
| | | | |
| | | | |
| Spouse: | | | |
| Children: | | | |
| | | | |
| | | | |

Any family history of liver disease?

*What relative?* _____

Any family history of colon polyps or colon cancer?

*What relative & age at time of diagnosis:*

_____

Other: *please explain* _____
_____
_____

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## Surgical History

Please indicate the surgeries you have had and list the approximate date:

| | Yes | No | Date |
|---|---|---|---|
| Appendectomy | ☐ | ☐ | |
| Tonsillectomy | ☐ | ☐ | |
| Adenoidectomy | ☐ | ☐ | |
| Cataracts | ☐ | ☐ | |
| Right__ Left__ | | | |
| Gastrectomy | ☐ | ☐ | |
| Gastric Bypass | ☐ | ☐ | |
| Gastric Lap-band | ☐ | ☐ | |
| Hiatal Hernia repair | ☐ | ☐ | |
| Gallbladder | ☐ | ☐ | |
| Kidney Stones | ☐ | ☐ | |

| | Yes | No | Date |
|---|---|---|---|
| Cystoscopy | ☐ | ☐ | |
| Lithotripsy | ☐ | ☐ | |
| GYN Laparoscopy | ☐ | ☐ | |
| Hysterectomy | ☐ | ☐ | |
| total or partial | | | |
| Mastectomy | ☐ | ☐ | |
| total__ right__ left__ | | | |
| Tubal Ligation | ☐ | ☐ | |
| Ovarian Cyst | ☐ | ☐ | |
| Breast Biopsy | ☐ | ☐ | |

| | Yes | No | Date |
|---|---|---|---|
| Spine Surgery | ☐ | ☐ | |
| cervical__ lumbar__ | | | |
| Laminectomy | ☐ | ☐ | |
| Spinal Fusion | ☐ | ☐ | |
| Arthroscopic Shoulder | ☐ | ☐ | |
| Arthroscopic Knee | ☐ | ☐ | |
| Knee Replacement | ☐ | ☐ | |
| Right__ Left__ | | | |
| Shoulder Surgery | ☐ | ☐ | |
| Hip Replacement | ☐ | ☐ | |

| | Yes | No | Date |
|---|---|---|---|
| Colonoscopy | ☐ | ☐ | |
| Colon Resection | ☐ | ☐ | |
| Endoscopy | ☐ | ☐ | |
| Hemorrhoidectomy | ☐ | ☐ | |
| Angioplasty | ☐ | ☐ | |
| Stent Placement | ☐ | ☐ | |
| Valvular Heart Surgery | ☐ | ☐ | |
| Bypass Surgery | ☐ | ☐ | |

Please list any serious illness or condition:

_____

_____

_____

_____

_____