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

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:

_____

_____

_____

_____

_____