

Please complete both sides of this form. PLEASE PRINT

NAME _____ **AGE** _____ **DATE OF BIRTH** _____ **Gender** Male Female

PRIMARY PHYSICIAN _____ **REFERRING PHYSICIAN** _____

YOUR OCCUPATION _____ **CARDIOLOGIST** _____

INSURANCE _____ **OTHER PHYSICIAN** _____

PRIMARY REASON FOR VISIT TODAY / OTHER ABDOMINAL PROBLEMS:

- | | | | | |
|-----------------------------------------|-----------------------------------------|---------------------------------------------|---------------------------------------------|---------------------------------|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Black Stools | <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Crohn's Disease | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Soiling | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Irritable Bowel | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Screening | |

MEDICATION ALLERGIES & REACTIONS:

- | | | | | |
|------------|------------------------------|-----------------------------|-------------------------------------------|-------------------------------------|
| Latex | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Other Allergies: | <input type="checkbox"/> Reactions: |
| Penicillin | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____ |
| Sulfa | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | _____ |

MEDICATION COMPLETE LIST INCLUDING DOSAGE (EX. 5mg)

- | | | | |
|----------|------------------------------|-----------------------------|----------------------------------|
| Aspirin | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Others: |
| Plavix | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Warfarin | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |

- | | | |
|------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| DO YOU NEED ANTIBIOTICS WITH DENTAL PROCEDURES FOR CARDIAC OR JOINT ISSUES? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| CAN YOU CLIMB A FLIGHT OF STAIRS WITHOUT BECOMING WINDED? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| DO YOU HAVE SLEEP APNEA OR NEED A CPAP MACHINE? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

PAST HISTORY

Please check all that apply

- | | | | |
|---------------------------------------------|--------------------------------------------------|------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> IBS | <input type="checkbox"/> Hepatitis A / B / C | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> COPD/ Emphysema | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> GERD | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Gall Bladder Stones | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Anesthesia Problems |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Cirrhosis/Liver Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other Medical Problems: |
| | | <input type="checkbox"/> Heart Disease/Failure | _____ |

PAST SURGICAL HISTORY

Please check all that apply

- | | | |
|-----------------------------------------------|-------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Open Heart Surgery | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Upper Endoscopy |
| <input type="checkbox"/> Stents for the Heart | <input type="checkbox"/> Liver Biopsy | <input type="checkbox"/> Colonoscopy |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Other Surgeries: |
| <input type="checkbox"/> Gall Bladder Surgery | <input type="checkbox"/> Cesarean Section | _____ |

FAMILY HISTORY

Please check all that apply

- Colon Polyps
- Colon Cancer
- Liver Disease
- Crohn's Disease
- Ulcerative Colitis
- Gallbladder Disease
- Ulcer Disease
- IBS
- Celiac Disease

Has anyone in your Family had...

Please check all that apply

- Colorectal Cancer before age 50
- Two or more Lynch Syndrome Cancers
- Ten or more lifetime Colon Polyps in the family
- Uterine Cancer before age 50
- Ovarian/Stomach/Kidney/Brain/Small Bowel Cancer
- Been tested for Hereditary Risk of Cancer

SOCIAL HISTORY

MARITAL STATUS: Single Separated Married Divorced Widowed

ACTIVITY	YES	NO	How Much	ACTIVITY	YES	NO	How Much
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>		Tattoos	<input type="checkbox"/>	<input type="checkbox"/>	
Smoker	<input type="checkbox"/>	<input type="checkbox"/>		Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>		Body Piercing	<input type="checkbox"/>	<input type="checkbox"/>	
IV Drugs (Herion, Cocaine)	<input type="checkbox"/>	<input type="checkbox"/>		Dentures/Partial Plate	<input type="checkbox"/>	<input type="checkbox"/>	
Other Drugs:	<input type="checkbox"/>	<input type="checkbox"/>		Glasses/ Contacts	<input type="checkbox"/>	<input type="checkbox"/>	

VACCINATIONS HEPATITIS A. Yes No **HEPATITIS B** Yes No

REVIEW OF SYSTEMS: Please examine the symptoms listed below and check any that currently apply.

- | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><u>Constitutional</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight Loss | <p><u>Respiratory</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Short of Breath <input type="checkbox"/> Frequent Cough <input type="checkbox"/> Wheezing | <p><u>Neurological</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Dizziness <input type="checkbox"/> Headache <input type="checkbox"/> Numbness <input type="checkbox"/> Tremors | <p><u>Musculoskeletal</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Back Pain <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Joint Pain | <p><u>Integument</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Contact Allergy <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Rash |
| <p><u>HEENT</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Double Vision <input type="checkbox"/> Ear Infections <input type="checkbox"/> Eye Pain <input type="checkbox"/> Nasal Congest. <input type="checkbox"/> Sinus Infection <input type="checkbox"/> Sore Throat | <p><u>Cardiovascular</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest Pains <input type="checkbox"/> Extremity Pains <input type="checkbox"/> Palpitations <p><u>Genitourinary</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain Urinating <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Frequently Urination <input type="checkbox"/> Urine Incontinence <input type="checkbox"/> Urine Retention | <p><u>Metabolic/Endocrine</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Heat Intolerance <p><u>Psychiatry</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Increased Stress | <p><u>Hematologic</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Bleed Easy <input type="checkbox"/> Bruise Easy <p><u>Reproductive</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Breast Lumps <input type="checkbox"/> Breast Pain <input type="checkbox"/> Vaginal Discharge | <p><u>Immunologic</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Chemicals <input type="checkbox"/> Food Allergies <input type="checkbox"/> Poor Immunity |

Please provide your signature and date stating that you have filled this form out as accurately as possible.

Type your full name and date below as your digital signature.

Save and email your completed forms to Springfield@GastroHealth.com

Signature of Patient/Guardian/ Employee Obtaining Information

Date