Woodholme Gastroenterology Associates, PA

Board Certified in Gastroenterology

PATIENT INFORMATION

Name ______________________________ Title ____________________

Race____________ Ethnicity____________ Preferred Language ____________

ALLERGIES

❑ No known allergies ❑ No known drug allergies ❑ Other Allergies

❑ Codeine ❑ IV Contrast ❑ Latex ❑ Penicillin ______________________________

IMMUNIZATIONS

❑ None

❑ Flu Vaccine ❑ Hep A ❑ Hep B ❑ Pneumococcal ❑ Other ____________

PAST OR PRESENT MEDICAL ILLNESSES / PROBLEMS

GASTROINTESTINAL

❑ Barrett's Esophagus ❑ Celiac Sprue ❑ Colon Cancer ❑ Crohn's Disease

❑ Diverticulitis ❑ Esophageal Cancer ❑ Gallstones ❑ Gastrointestinal Bleeding

❑ Hemorrhoids ❑ Hepatitis A ❑ Hepatitis B ❑ Hepatitis C

❑ Irritable Bowel Syndrome (IBS) ❑ Liver Cancer ❑ Pancreatitis ❑ Pancreatic Cancer

❑ Reflux, Esophageal ❑ Stomach Cancer ❑ Ulcer ❑ Ulcerative Colitis

❑ Other ______________________________

CARDIAC

❑ Atrial Fibrillation ❑ Heart Attack ❑ Heart Murmurs ❑ Pacemaker or Defibrillator

❑ Stents ❑ Other ______________________________

CANCER (NON GI)

❑ Breast Cancer ❑ Gyn Cancer ❑ Lung Cancer ❑ Prostate Cancer

❑ Other ______________________________

OTHER

❑ Anemia ❑ Arthritis ❑ Asthma ❑ Bleeding Disorder

❑ Depression ❑ Diabetes ❑ Dialysis ❑ Emphysema

❑ Endometriosis ❑ Glaucoma ❑ High Blood Pressure ❑ High Cholesterol

❑ History of Anxiety Disorder ❑ History of Blood Transfusion ❑ HIV ❑ Kidney Disease

❑ Kidney Stones ❑ Lupus ❑ Peripheral Vascular Disease ❑ Rheumatoid Arthritis

❑ Seizure disorder ❑ Sexually transmitted disease(s) ❑ Skin disease ❑ Sleep Apnea

❑ Stroke ❑ Thyroid Disease ❑ Urinary Infections ❑ Other ____________

PREVIOUS GI PROCEDURES

❑ Bravo capsule (pH probe) ❑ Capsule Endoscopy ❑ Colonoscopy ❑ Endoscopy/EGD

❑ ERCP ❑ Sigmoidoscopy ❑ Other________________________________

PREVIOUS SURGERIES

❑ Aortic Surgery ❑ Appendectomy ❑ Cardiac Surgery ❑ Colon Surgery/Colostomy

❑ Gallbladder removed ❑ Gastric bypass/obesity surgery ❑ Heart valve replacement/repair

❑ Hernia replacement/repair ❑ Hysterectomy ❑ Joint Surgery/replacement ❑ Liver Surgery

❑ Mastectomy ❑ Tonsillectomy ❑ Other________________________________

FAMILY MEDICAL HISTORY

❑ No knowledge of family history

DIAGNOSES	Mother	Father	Sister	Brother	Grandmother	Grandfather	Other
Celiac Disease	❑	❑	❑	❑	❑	❑	❑
Ulcerative Colitis	❑	❑	❑	❑	❑	❑	❑
Crohn's Disease	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑
Esophageal Cancer	❑	❑	❑	❑	❑	❑	❑
GYN Cancer	❑	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑	❑	❑	❑
Liver Disease	❑	❑	❑	❑	❑	❑	❑
Pancreatic Disease	❑	❑	❑	❑	❑	❑	❑
Stomach Cancer	❑	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑	❑
Colon Polyps	❑	❑	❑	❑	❑	❑	❑
Colon Cancer	❑	❑	❑	❑	❑	❑	❑
Age at Diagnosis	______	______	______	______	______	______	______

Other________________________________

SOCIAL HISTORY

Occupation	Number of Children

MARITAL STATUS

❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Civil Union ❑ Other

ALCOHOL ❑ None ❑ Social ❑ Daily ❑ Quit

TOBACCO ❑ Current everyday ❑ Current some days ❑ Former smoker ❑ Never smoked
❑ Current status unknown ❑ Unknown

ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS?

GASTROINTESTINAL

❑ NONE	YES	NO
Abdominal pain	❑	❑
Belching	❑	❑
Black stool	❑	❑
Bloating	❑	❑
Blood in stool	❑	❑
Change in bowel habits	❑	❑
Constipation	❑	❑
Diarrhea	❑	❑
Gas	❑	❑
Heartburn	❑	❑
Jaundice	❑	❑
Loss of appetite	❑	❑
Milk/lactose intolerance	❑	❑
Nausea	❑	❑
Pain with Bowel Movement	❑	❑
Rectal bleeding	❑	❑
Rectal pain	❑	❑
Stool incontinence	❑	❑
Trouble swallowing	❑	❑
Vomiting	❑	❑

CARDIOVASCULAR

❑ NONE	YES	NO
Angina/chest pressure	❑	❑
Ankle swelling	❑	❑
Chest pain	❑	❑
Irregular heart beat	❑	❑

CONSTITUTIONAL

❑ NONE	YES	NO
Fever	❑	❑
Sweats	❑	❑
Weight gain	❑	❑
Weight loss	❑	❑

ENMT

❑ NONE	YES	NO
Bleeding gums	❑	❑
Burning tongue	❑	❑
Change in vision	❑	❑
Dry eyes	❑	❑
Dry mouth	❑	❑
Eye pain	❑	❑
Hoarseness	❑	❑
Mouth sores	❑	❑
Nose bleeds	❑	❑
Sore throat	❑	❑

ENDOCRINE

❑ NONE	YES	NO
Excessive thirst	❑	❑
Hair change	❑	❑
Excessive urination	❑	❑

GENITOURINARY

❑ NONE	YES	NO
Blood in urine	❑	❑
Change in urinary frequency	❑	❑
Difficulty w/ urination	❑	❑
Irregular menstruation	❑	❑
Sexual difficulty	❑	❑

HEMATOLOGIC/LYMPHATIC

❑ NONE	YES	NO
Enlarged glands	❑	❑
Prolonged bleeding	❑	❑

SKIN

❑ NONE	YES	NO
Itching	❑	❑
Rashes	❑	❑

MUSCULOSKELETAL

❑ NONE	YES	NO
Muscle weakness	❑	❑
Stiff joints	❑	❑
Swollen joints	❑	❑

NEUROLOGICAL

❑ NONE	YES	NO
Frequent headaches	❑	❑
Numbness or tingling	❑	❑
Paralysis	❑	❑
Seizures	❑	❑

RESPIRATORY

❑ NONE	YES	NO
Cough	❑	❑
Shortness of breath	❑	❑

PSYCHIATRIC

❑ NONE	YES	NO
Anxiety	❑	❑
Depression	❑	❑
Difficulty sleeping	❑	❑
Memory loss/confusion	❑	❑