Southeastern Indiana Gastroenterology™ L.L.C.

Today's Date: _____

Name: _____

Birth Date: _____ Weight:_____ Marital Status: S M D W

Number of children: _____ Number of Siblings: _____

Occupation: _____ Employer: _____

Family Doctor: _____ Cardiologist: _____

**Reason for today's appointment: _____

CURRENT MEDICATIONS (please include both prescription and over the counter used daily or as needed)

MEDICATION NAME:	DOSE:	HOW OFTEN TAKEN:	USED FOR:
Example: Ibuprofen	*200 mg*	*2 pills twice daily*	*Arthritis*

ALLERGIES

NAME: *(example: Penicillin)*	REACTION: *(example: Hives)*

I have a known allergy to (circle): Iodine Latex Chemicals Anesthetics Succinylcholine

PERSONAL HABITS

Current cigarette or cigar use: Yes No If yes, # of packs per day:_____

If prior smoker, quit date:_____ # of years as a smoker: _____

Chewing tobacco/pipe use: Yes No # of years of use: _____

Consume alcoholic beverages: Yes No If yes, type of beverage:_____ # of drinks per week:_____

History of alcohol abuse: Yes No

Current or past use of recreational drugs: Yes No If yes, type _____ Quit year_____

Special diet/restrictions:_____

Number of caffeinated beverages per day: _____

Use of antibiotics in the past 1-2 months: Yes No

FAMILY HISTORY

Father's age: _____ Deceased Yes No Medical Conditions: _____

Mother's age:_____ Deceased Yes No Medical Conditions: _____

Do you have ***blood relatives*** with any of the following medical conditions?

CONDITION	RELATION TO YOU / AGE AT DIAGNOSIS	CONDITION	RELATION TO YOU / AGE AT DIAGNOSIS
Crohn's or Ulcerative Colitis	_____ / _____	Colon Cancer	_____ / _____
Early Heart Disease	_____ / _____	Colon Polyps	_____ / _____
Diabetes Mellitus	_____ / _____	Ovarian, Breast, Uterine Cancer	_____ / _____
Peptic Ulcer Disease	_____ / _____	Stomach Cancer	_____ / _____
Gallbladder Disease	_____ / _____	Esophageal Cancer	_____ / _____
Lupus	_____ / _____	Other Cancers	_____ / _____
Celiac Disease	_____ / _____	Pancreas/Liver Disease/Cirrhosis	_____ / _____

CURRENT SYMPTOMS. Place ✔ next to any symptoms you are currently experiencing.

CONSTITUTIONAL
- ☐ Fever or chills
- ☐ Night sweats
- ☐ Fatigue

APPETITE
- ☐ Loss of appetite
- ☐ Loss of weight
- ☐ Increase in weight

GASTROINTESTINAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn/acid reflux
- ☐ Painful swallowing
- ☐ Food sticking in throat or choking
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in the stool
- ☐ Black stools
- ☐ Loss of control of bowel movements

PULMONARY SYMPTOMS
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing

HEART SYMPTOMS
- ☐ Chest pain
- ☐ Irregular heart beat or palpitations
- ☐ Heart murmur
- ☐ Swelling/edema of the feet or ankles

NERVOUS SYSTEM
- ☐ Dizziness
- ☐ Fainting
- ☐ Numbness/tingling of legs or hands

HEAD, EYES, NOSE, THROAT
- ☐ Headaches
- ☐ Eye disease
- ☐ Sinus problems
- ☐ Mouth disease (dry/sores)

GENITO-URINARY
- ☐ Pain or burning with urination
- ☐ Leaking urine
- ☐ Blood in the urine
- ☐ Kidney stones

MUSCULOSKELETAL
- ☐ Back pain or muscles aching
- ☐ Pain, swelling or stiffness in joints

SKIN
- ☐ Skin rash or condition
- ☐ Itching
- ☐ Flushing

HEMATOLOGIC / ENDOCRINE
- ☐ Enlarged lymph nodes
- ☐ Easy bruising or bleeding
- ☐ Hot / cold intolerance

EXPOSURES IN THE PAST YEAR
- ☐ Well water
- ☐ Foreign travel
- ☐ Camping, fishing, hunting, ticks
- ☐ Chemical exposures

YOUR MEDICAL HISTORY (Please ✔ any conditions that you are treated/medicated for or have been diagnosed with)

METABOLIC
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Addison's Disease
- ☐ Lupus
- ☐ Other _____

NEUROLOGY
- ☐ Stroke
- ☐ TIA
- ☐ Seizures
- ☐ Migraines
- ☐ Parkinson's
- ☐ Multiple Sclerosis
- ☐ Dementia
- ☐ Restless Leg Syndrome
- ☐ Neuropathy
- ☐ Other _____

CARDIAC
- ☐ Chest Pain
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Atrial Fibrillation
- ☐ Murmur
- ☐ Irregular Heart Rate
- ☐ Other _____

PULMONARY
- ☐ Sleep Apnea
- ☐ Use of Oxygen
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Other _____

ONCOLOGY
- ☐ Cancer type: _____
  Year diagnosed: _____
- ☐ Treatment Chemo, Radiation and/or Surgery
- ☐ Other _____

HEMATOLOGY
- ☐ Anemia
- ☐ Received a Blood Transfusion
- ☐ Blood Clots (DVT or PE)
- ☐ Other _____

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Chronic Back Pain
- ☐ Carpal Tunnel
- ☐ Other

RENAL
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ Benign Prostate Hypertrophy (BPH)
- ☐ Interstitial Cystitis
- ☐ Dialysis
- ☐ Incontinence (leaking urine)
- ☐ Other _____

EYES
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Other _____

INFECTIOUS
- ☐ Herpes
- ☐ Shingles
- ☐ STD if yes, type _____
- ☐ Tuberculosis
- ☐ Positive PPD skin test
- ☐ Other _____

MENTAL HEALTH
- ☐ Alzheimers
- ☐ Anxiety
- ☐ Depression
- ☐ Panic Attacks
- ☐ OCD
- ☐ PTSD
- ☐ ADD
- ☐ Alcoholism
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Bulimia/Anorexia
- ☐ Other _____

WOMEN'S HEALTH
- ☐ Endometriosis
- ☐ Ovarian Cysts
- ☐ Irregular Menstruation
- ☐ Uterine Fibroids
- ☐ PCOS
- ☐ Other

ALLERGY
- ☐ Frequent Sinus Infections
- ☐ Seasonal Allergies
- ☐ Hayfever
- ☐ Anaphylaxis
- ☐ Other _____

GASTROINTESTIONAL
- ☐ GERD
- ☐ Fatty Liver
- ☐ Cirrhosis
- ☐ Pancreatitis
- ☐ H. Pylori infection
- ☐ Ulcer
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Irritable Bowel Syndrome
- ☐ Hepatitis
- ☐ Celiac Disease
- ☐ Other _____

IMPLANTABLE DEVICES
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Pain Pump
- ☐ Insulin Pump
- ☐ Neuro or bladder stimulator
- ☐ Cardiac Stents
- ☐ Gastric Pacemaker
- ☐ Other _____

SURGERY (please include all childhood and adult surgeries)	**YEAR**	**SURGERY**	**YEAR**

PRIOR ENDOSCOPIC PROCEDURES

Prior colonoscopy: Yes No Year: _____ Location: _____
Were polyps removed? Yes No
Prior EGD (Endoscopy): Yes No Year: _____ Location: _____