CENTRAL FLORIDA GASTROENTEROLOGY
a division of internal medicine specialists

Circle all that apply (add any additional please)

Patient Name: _____ Today's date: _____

Reason for visit today:

_____

Medications:
Please bring everything you take (prescription *and* over the counter medications) in their bottles please.

Allergies to medications:

_____

Previous Tests (when, where and results):
Colonoscopy _____

Gastroscopy _____

CT Abdomen/Pelvis _____

Ultrasound _____

Liver Biopsy _____

GI Medical Problems (circle all that apply):
Polyps, Cancer of the _____, GERD, Rectal Bleeding, Liver Disease, Colitis (UC / Crohn's / other), Celiac Disease, Lupus, Scleroderma, Pancreatitis, Nausea, Diarrhea, Constipation, Weight loss, Anemia, alcohol abuse, Barrett's Esophagus, Schatzki Ring, Other(s): _____

Other Medical Problems (circle all that apply):
Have you ever received chemotherapy, radiation therapy or other treatments for any condition? Yes / No

High Blood Pressure, Diabetes, High Cholesterol, Angina, heart attack, heart murmur, Anemia, Arthritis, Asthma, Atrial Fibrillation, BPH, COPD, Epilepsy, Glaucoma, Macular Degeneration, Sickle Cell, Gout, Cancer of the _____, Bladder problems, BPH (Prostate enlarged), Heart Problems, Liver Problems, Anemia, Pulmonary Problems, Environmental Allergies, Other(s): _____

complete front and back

(BACK)

Surgeries (circle all that apply):
Gallbladder, Hysterectomy (total or partial), C-Section (# _____), Appendectomy, Open Heart (# bypass _____ , valve replacement, pacemaker), Gastric Bypass, Cataract, Hemorrhoidectomy, Hip Replacement, Hernia Repair, Back Surgery, Knee (Replacement, Arthroscopy), Breast (Mastectomy, Lumpectomy), TURP, Plastic Surgery, other(s) _____

Family History (circle all that apply):
Any family history of colon cancer, stomach cancer, polyps or GI diseases: yes / no. List :_____

Father: alive/deceased Health Problems / Cause of Death: _____
Mother: alive/deceased Health Problems / Cause of Death _____
Sisters/Brothers: Brothers _____ Sisters _____ Are they healthy? Yes / No
Children: Sons _____ Daughters _____ Are they healthy? Yes / No

Social History (circle all that apply):
Have you ever received a blood transfusion? Yes / No When? _____

Marital Status: Married / Divorced / Single / Widowed / Separated / Life Partner / Other
Occupation: _____
Tobacco: ____ ppd for _____ years / None / Quit after _____ years of _____ ppd
Alcohol: _____ Caffeine: _____ cups of coffee, cola or tea per day
Recreational Drugs: never / current / past: IV drugs / Cocaine / marijuana / others

Review of Systems: (circle all that apply)

Allergy: Itchy eyes, runny nose, scratchy throat, sinus congestion

General: Fatigue

Dermatology: mole, rash, hives

Ophthalmology: blurred vision, eye irritation

ENT, Respiratory: shortness of breath, nose bleeds, vocal changes, cough

Cardiology: chest pain, leg edema, palpitations

Gastroenterology: Abdominal pain, rectal bleeding, change in bowel habits, weight loss, nausea, vomiting, heartburn, difficulty swallowing, painful swallowing, constipation, diarrhea, vomiting blood, black tarry stools, rectal pain, gas, incontinence, feeling full early in a meal, anorexia, fever, jaundice

Urology: blood in urine, difficulty urinating, frequent urination

Neurology: headache, insomnia, seizures

Psychology: memory loss, considering suicide, depression, anxiety, sleep disturbances

Musculoskeletal: joint pain, leg cramps, gout

Endocrinology: heat intolerance, frequent urination, excessive thirst, excessive sweating

Hematology: bleeding or bruising, anemia, past transfusion