Patient Name: _____ DOB: _____ Today's Date: _____

Pharmacy Name/Address/ Phone #: _____

Reason for your visit today:_____

_____

_____

_____

_____

_____

Medications (include over-the-counter medications)
(include medication name, dosage, and frequency)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medication Allergies (include reactions)

_____

_____

_____

_____

_____

TO BE COMPLETED BY CLINICAL STAFF AT TIME OF APPOINTMENT

Weight:_____ BP:_____ Pulse:_____ Respirations:_____

Medical History

(do you have or have you ever had)

- ☐ Anemia
- ☐ Colon Polyps
- ☐ Colon Cancer
- ☐ Cancer (type) _____
- ☐ Ulcers
- ☐ Reflux (GERD)
- ☐ Barrett's Esophagus
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Irritable Bowel Syndrome
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Sleep Apnea
- ☐ Tuberculosis
- ☐ Seasonal Allergies
- ☐ Thyroid Disorders
- ☐ Other
- ☐ Coronary Artery Heart Disease
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation
- ☐ Valvular Heart Disease
- ☐ Valve Replacement
- ☐ Blood Clots
- ☐ High Cholesterol
- ☐ Headaches (chronic)
- ☐ Stroke
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Urinary Infections
- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Seizure Disorder
- ☐ Glaucoma

_____

_____

_____

Past Surgical History

- ☐ Gallbladder Removed
- ☐ Appendix Removed
- ☐ Stomach Surgery
- ☐ Colon Surgery
- ☐ Hysterectomy
- ☐ Orthopedic Surgery
- ☐ Implanted Device
- ☐ Other: _____
- ☐ Mastectomy
- ☐ Prostate Surgery
- ☐ Thyroid Surgery
- ☐ RadiationTherapy
- ☐ Hernia Repair
- ☐ Coronary Artery Bypass Surgery

_____

Family History (Parents and/or siblings)

- ☐ Liver Disease
- ☐ Cirrhosis
- ☐ Colon Cancer
- ☐ Colon Polyps
- ☐ Ulcerative Colitis
- ☐ Stomach Cancer
- ☐ Crohn's Disease
- ☐ Gallbladder Disease
- ☐ Anemia
- ☐ Pelvic Cancer
- ☐ Breast Cancer

Social History

- ☐ Alcohol Use
- ☐ Social Drinker ☐ Moderate (2 drinks/day or less)
- ☐ Heavy use ☐ Recovering Alcoholic
- ☐ Smoking ☐ How many years?_____
- ☐ Packs per Day?_____
- ☐ Previous History of Smoking
- ☐ Illicit Drug Use ☐Using Intravenous Drugs?_____
- ☐ Current Drug Use ☐ Past Drug Use

TUCSON GASTROENTEROLOGY SPECIALISTS, PC
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Phone (520) 327-3454 • Fax (520) 327-3431 • Toll Free (866) 755-7996

Please complete additional information on reverse side.

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

- ☐ Weight Change
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Fatigue
- ☐ Earache
- ☐ Ringing in the ears
- ☐ Nosebleeds
- ☐ Mouth sores
- ☐ Bleeding gums
- ☐ Dentures (do you have)
- ☐ Hoarseness
- ☐ Painful swallowing
- ☐ Lump in throat
- ☐ Chest pain or discomfort
- ☐ Palpitations
- ☐ Shortness of breath with exertion
- ☐ Leg cramps/pain
- ☐ Cough
- ☐ Sputum production
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Bad breath
- ☐ Anorexia
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Regurgitation
- ☐ Dysphagia
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black tarry stools
- ☐ Blood in stool
- ☐ Abdominal pain
- ☐ Mucus in stool
- ☐ Belching
- ☐ Abdominal bloating
- ☐ Painful urination
- ☐ Increased urinary frequency
- ☐ Frequent urination at night
- ☐ Blood in urine
- ☐ Itching
- ☐ Skin rashes
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ Excessive vaginal bleeding
- ☐ Hair loss
- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Swollen glands in neck
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Muscle aches
- ☐ Chronic headaches
- ☐ Eyesight problems
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle Weakness
- ☐ Numbness, tingling
- ☐ Sleep disturbances
- ☐ Anxiety
- ☐ Depression

Have you **recently (within 1 year)** completed a 3 day stool card?_____ Result_____

Have you ***EVER*** had any of the following:

EGD (upper endoscopy, a tube is placed down your throat to look at the esophagus and stomach, you are sedated) ☐ Yes ☐ No
When?_____ Where?_____ Why?_____

Flexible Sigmoidoscopy (half of the colon is looked at with a tube, no sedation) ☐ Yes ☐ No
When?_____ Where?_____ Why?_____

Colonoscopy (lower endoscopy, all of your colon is looked at with a tube, you are sedated) ☐ Yes ☐ No
When?_____ Where?_____ Why?_____

What tests, **RELATED TO WHY YOU ARE HERE**, have recently been done?

	When?	Where?	Why?
EKG			
Chest X-Ray			
Upper GI (x-ray)			
Ultrasound of abdomen			
Barium enema (x-ray)			
CAT scan of abdomen			
MRI of abdomen			
Labs			