

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Referring MD: \_\_\_\_\_

Have you been having any of the following symptoms?	
<b>YES</b>	<b>YES</b>
<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Unintentional Weight Loss	<input type="checkbox"/> Endocarditis/ Infected Heart Valve
<input type="checkbox"/> Unintentional Weight Gain	<input type="checkbox"/> Defibrillator Placement /Pacemaker
<input type="checkbox"/> Fevers, Chills or Sweats	<input type="checkbox"/> Heart Valve Replacement
<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Painful Swallowing	<input type="checkbox"/> Palpitations/ Irregular Heart Beat
<input type="checkbox"/> Heartburn/ Indigestion	<input type="checkbox"/> Pain in Calves when Walking
<input type="checkbox"/> Regurgitation of liquid/ food	<input type="checkbox"/> Weakness/ Numbness
<input type="checkbox"/> History of Ulcers	<input type="checkbox"/> Blacking out Spells
<input type="checkbox"/> Recurrent Vomiting	<input type="checkbox"/> Seizures
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Chest Pain/ Tightness
<input type="checkbox"/> Recurrent Constipation	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Recurrent Diarrhea	<input type="checkbox"/> History of Sleep Apnea/CPAP
<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Painful Urination
<input type="checkbox"/> Rectal Pain	<input type="checkbox"/> History of Kidney Problems
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Arthritis/ Joint Pain
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Recurrent Skin Rash
<input type="checkbox"/> History of Blood Transfusion	<input type="checkbox"/> Panic Attacks/ Anxiety
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression
<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> History of Thyroid Disease
<input type="checkbox"/> Stent or Graft placement	<input type="checkbox"/> Hair Loss

Please list any past/present medical problems & date (diabetes, high blood pressure, heart attack, etc.)				
Date	Medical Problem	Date	Medical Problem	

Please list any operations or hospitalizations & approximate year				
Year	Operation/ Hospitalization	Year	Operation/ Hospitalization	ization

Do you or have you ever:			
Smoked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Packs per day _____ / years smoking _____
Used Snuff, Chew, Pipes, Cigars?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Drink Alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	What type and how much/week?

Marital Status?:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Children?	Number _____ Ages _____ Last Menstrual Period _____			

<b>Has anyone in your FAMILY had:</b>			
<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Uterine Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Other ____ _____ _____ _____ _____
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Bladder Cancer	<input type="checkbox"/> Heart Attack	
<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Stomach Cancer	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Pancreatitis	
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anemia	
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Hemochromatosis	
<input type="checkbox"/> Ovarian Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Celiac Sprue	

<b>Have you had any previous Gastrointestinal studies/tests?</b>	<b>When /where?</b>
<input type="checkbox"/> Stool testing _____	
<input type="checkbox"/> CAT scan or MRI _____	
<input type="checkbox"/> Upper GI series _____	
<input type="checkbox"/> Colonoscopy _____	
<input type="checkbox"/> Upper Endoscopy (EGD) _____	
<input type="checkbox"/> Ultrasound _____	

<b>Medications (Please list all over the counter meds, vitamins, and prescriptions)</b>

<b>Allergies to any medications</b>

**Pharmacy name and number:** \_\_\_\_\_

**Phone number that is secure for us to leave a voicemail regarding any medical information**

\_\_\_\_\_

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date