

**The Gastroenterology Group, P.A.**  
**Patient Information Form**

**Patient's Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Reason for your visit today** \_\_\_\_\_

**Medical History** (please list any medical problems you have/had)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Surgical History** (please list any surgeries you've had, include dates)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Hospitalizations** (please list reasons and dates of prior hospitalizations)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications** - please include dosage and how many times per day the medication is taken (include vitamins, supplements, and over the counter medications)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies/Intolerance** (include medications and food)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Latex Yes \_\_\_ No \_\_\_

Iodine Yes \_\_\_ No \_\_\_

**Females** Is there a chance you could be pregnant? Yes \_\_\_ No \_\_\_

When was your last menstrual period? \_\_\_\_\_

**Social History**

Smoking Yes \_\_\_ No \_\_\_ Former \_\_\_ \_\_\_ cigarettes per day for \_\_\_ years

Alcohol Yes \_\_\_ No \_\_\_ Former \_\_\_ What type and how much? \_\_\_\_\_

Occupation \_\_\_\_\_

**Family History**

- Colon Cancer     Cirrhosis  
 Colon Polyps     Liver disease  
 Other

Please provide details \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Review of Symptoms

Please indicate with a check if you've had these symptoms recently

### Gastrointestinal

- Rectal bleeding
- Black or tarry stools
- Vomiting blood
- Nausea
- Abdominal pain
- Reflux/heartburn
- Belching/gas
- Change in bowel habits
- Vomiting
- Bloating
- Diverticulitis
- Diarrhea
- Constipation
- Difficulty swallowing

### General

- Fatigue
- Weight loss
- Change in appetite
- Fever
- Weight gain
- Chills
- Trouble sleeping

### Ophthalmologic

- Dry eye
- Blurred vision
- Floaters
- Decreased visual acuity
- Red eye

### Ear, nose, throat

- Ear pain
- Decreased hearing
- Ringing in the ears
- Dry mouth
- Sore throat

### Endocrine

- Excessive thirst
- Cold intolerance
- Heat intolerance
- Excessive sweating

### Respiratory

- Shortness of breath at rest
- Chest pain
- Shortness of breath with exertion
- Cough
- Wheezing

### Cardiovascular

- Leg pain while walking
- Chest pain at rest
- Fluid accumulation in legs
- Chest pain with exertion
- Irregular heart beat

### Hematology

- Easy bruising
- Swollen glands

### Genitourinary

- Frequent urination
- Blood in the urine
- Painful urination
- Difficulty urinating

### Musculoskeletal

- Muscle aches
- Joint stiffness
- Painful joints
- Leg cramps
- Swollen joints

### Dermatology

- Hives
- Dry skin
- Itching
- Eczema
- Rash

### Neurologic

- Headache
- Seizures
- Dizziness
- Loss of strength
- Tingling/numbness
- Fainting
- Memory loss
- Tremor

### Psychiatric

- Eating disorders
- Anxiety
- Stressors
- Depressed mood

I have reviewed both pages of this form. I have responded to the best of my ability and recall regarding all previous and current illnesses.

Signature \_\_\_\_\_ Date \_\_\_\_\_