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 Please provide details _____
□ Colon Polyps □ Liver disease _____
□ Other _____

Review of Symptoms

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

Gastrointestinal	□ Abdominal pain	□ Bloating
□ Rectal bleeding	□ Reflux/heartburn	□ Diverticulitis
□ Black or tarry stools	□ Belching/gas	□ Diarrhea
□ Vomiting blood	□ Change in bowel habits	□ Constipation
□ Nausea	□ Vomiting	□ Difficulty swallowing
General	□ Change in appetite	□ Chills
□ Fatigue	□ Fever	□ Trouble sleeping
□ Weight loss	□ Weight gain	
Ophthalmologic	□ Blurred vision	□ Decreased visual acuity
□ Dry eye	□ Floaters	□ Red eye
Ear, nose, throat	□ Decreased hearing	□ Dry mouth
□ Ear pain	□ Ringing in the ears	□ Sore throat
Endocrine	□ Cold intolerance	□ Excessive sweating
□ Excessive thirst	□ Heat intolerance	
Respiratory	□ Chest pain	□ Cough
□ Shortness of breath at rest	□ Shortness of breath with exertion	□ Wheezing
Cardiovascular	□ Chest pain at rest	□ Chest pain with exertion
□ Leg pain while walking	□ Fluid accumulation in legs	□ Irregular heart beat
Hematology	□ Easy bruising	□ Swollen glands
Genitourinary	□ Blood in the urine	□ Difficulty urinating
□ Frequent urination	□ Painful urination	
Musculoskeletal	□ Joint stiffness	□ Leg cramps
□ Muscle aches	□ Painful joints	□ Swollen joints
Dermatology	□ Dry skin	□ Eczema
□ Hives	□ Itching	□ Rash
Neurologic	□ Dizziness	□ Fainting
□ Headache	□ Loss of strength	□ Memory loss
□ Seizures	□ Tingling/numbness	□ Tremor
Psychiatric	□ Anxiety	□ Depressed mood
□ Eating disorders	□ Stressors	

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_____