

**GASTROENTEROLOGY - HISTORY & PHYSICAL** DATE \_\_\_\_\_

NAME \_\_\_\_\_ MARITAL STATUS  M  W  D  SEP DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE (H) \_\_\_\_\_ (O) \_\_\_\_\_

OCCUPATION / EMPLOYER \_\_\_\_\_ INS # \_\_\_\_\_ REFERRED BY \_\_\_\_\_

**CHIEF COMPLAINTS** \_\_\_\_\_

1) <input type="checkbox"/> APPETITE	23) <input type="checkbox"/> PANCREATITIS
2) <input type="checkbox"/> WT CHANGE	24) <input type="checkbox"/> BOWEL SURG
3) <input type="checkbox"/> FEVER	25) <input type="checkbox"/> DIARRHEA
4) <input type="checkbox"/> CANCER	26) <input type="checkbox"/> CONSTIPATION
5) <input type="checkbox"/> ANEMIA	27) <input type="checkbox"/> LAXATIVE USE
6) <input type="checkbox"/> DYSPHAGIA	28) <input type="checkbox"/> MELENA
7) <input type="checkbox"/> REGURG	29) <input type="checkbox"/> CELIAC DIS
8) <input type="checkbox"/> BELCHING	30) <input type="checkbox"/> CROHN'S
9) <input type="checkbox"/> HEARTBURN	31) <input type="checkbox"/> COLITIS
10) <input type="checkbox"/> NAUSEA	32) <input type="checkbox"/> POLYPS
11) <input type="checkbox"/> VOMITING	33) <input type="checkbox"/> DIVERTIC
12) <input type="checkbox"/> HEMATEM	34) <input type="checkbox"/> STOOLS -
13) <input type="checkbox"/> PUD	<input type="checkbox"/> BLOOD
14) <input type="checkbox"/> ABD PAIN	<input type="checkbox"/> MUCUS
15) <input type="checkbox"/> BLOATING	<input type="checkbox"/> PUS
16) <input type="checkbox"/> IBS	<input type="checkbox"/> INCONT
17) <input type="checkbox"/> P PRAN PAIN	36) <input type="checkbox"/> HEMORR
18) <input type="checkbox"/> FOOD INTOL	36) <input type="checkbox"/> TENESMUS
19) <input type="checkbox"/> GALLSTONES	37) <input type="checkbox"/> FISTULA
20) <input type="checkbox"/> JAUNDICE	38) <input type="checkbox"/> FISSURES
21) <input type="checkbox"/> HEPATITIS	39) <input type="checkbox"/> ENEMA USE
22) <input type="checkbox"/> BLOOD TRANS	40) <input type="checkbox"/>

**PERSONAL HISTORY** Cig (# / day / # yrs) \_\_\_\_\_ Alcohol (oz / day) \_\_\_\_\_ Coffee (cups / day) \_\_\_\_\_ Street Drugs \_\_\_\_\_

MEDICATIONS (DOSAGE / FREQ)	ASA / NSAID'S - OTC	RESP	YEAR	REASON	YEAR	REASON

**ALLERGIES**

FAMILY HX	5) <input type="checkbox"/> ASTHMA	10) <input type="checkbox"/> HYPERT	15) <input type="checkbox"/> PUD	#	RELATIVE	#	RELATIVE
1) <input type="checkbox"/> EPILEPSY	6) <input type="checkbox"/> ARTHRITIS	11) <input type="checkbox"/> CELIAC DIS	16) <input type="checkbox"/> COLITIS				
2) <input type="checkbox"/> STROKE	7) <input type="checkbox"/> KIDNEY DIS	12) <input type="checkbox"/> CANCER	17) <input type="checkbox"/> CROHN'S				
3) <input type="checkbox"/> MENTAL DIS	8) <input type="checkbox"/> ANEMIA	13) <input type="checkbox"/> COLON CANCER	18) <input type="checkbox"/> PANCR				
4) <input type="checkbox"/> DIABETES	9) <input type="checkbox"/> HEART DIS	14) <input type="checkbox"/> POLYPS	19) <input type="checkbox"/> LIVER DIS				

**PAST MEDICAL HISTORY**  WWI

1) <input type="checkbox"/> EENT	<input type="checkbox"/> VISION	<input type="checkbox"/> HEARING	<input type="checkbox"/> VERTIGO	<input type="checkbox"/> NOSE BLEEDS
1) <input type="checkbox"/> RESP	<input type="checkbox"/> SOB	<input type="checkbox"/> BRONCHITIS	<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> ASTHMA
1) <input type="checkbox"/> C VASC	<input type="checkbox"/> HYPERT	<input type="checkbox"/> CAD	<input type="checkbox"/> HEART MURM - VALVE	<input type="checkbox"/> ARRHYTHMA
1) <input type="checkbox"/> P VASC	<input type="checkbox"/> HT CLAUD	<input type="checkbox"/> V VEINS	<input type="checkbox"/> PHLEBITIS	
1) <input type="checkbox"/> ONC / HEM	<input type="checkbox"/> CANCER	<input type="checkbox"/> ANEMIA	<input type="checkbox"/> BLOOD DIATH	<input type="checkbox"/> SICKLE CELL
1) <input type="checkbox"/> GU	<input type="checkbox"/> UTI	<input type="checkbox"/> BLADDER	<input type="checkbox"/> KIDNEY	<input type="checkbox"/> PROSTATE
1) <input type="checkbox"/> ENDO	<input type="checkbox"/> DIABETES	<input type="checkbox"/> THYROID		
1) <input type="checkbox"/> NEURO	<input type="checkbox"/> STROKE	<input type="checkbox"/> MIGRAINE	<input type="checkbox"/> SEIZURES	
1) <input type="checkbox"/> ARTH	<input type="checkbox"/> ARTHRALGIA	<input type="checkbox"/> GOUT	<input type="checkbox"/> OSTEOPOROSIS	
0) <input type="checkbox"/> DERM	<input type="checkbox"/> RASHES	<input type="checkbox"/> HIVES	<input type="checkbox"/> ECZEMA	<input type="checkbox"/> HERPETIFORMIS
1) <input type="checkbox"/> MENT ILL	<input type="checkbox"/> ANX NEUR	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> SLEEP DISORDER	
2) <input type="checkbox"/> INFECT	<input type="checkbox"/> RHEUM FEVER	<input type="checkbox"/> TB	<input type="checkbox"/> STD	
3) <input type="checkbox"/> FEMALES	# PREG _____	LMP _____	<input type="checkbox"/> BIRTH CONTROL	<input type="checkbox"/> MENOPAUSE