Reset Form

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Please complete both sides of this form. PLEASE PRINT

NAME _____ **AGE** _____ **DATE OF BIRTH**_____ **Gender** ☐ Male ☐ Female

PRIMARY PHYSICIAN _____ **REFERRING PHYSICIAN**_____

YOUR OCCUPATION _____ **CARDIOLOGIST** _____

INSURANCE _____ **OTHER PHYSICIAN** _____

PRIMARY REASON FOR VISIT TODAY / OTHER ABDOMINAL PROBLEMS:

☐ Abdominal Pain	☐ Bleeding	☐ Heartburn	☐ Ulcerative Colitis	☐ Other:
☐ Constipation	☐ Black Stools	☐ Trouble swallowing	☐ Crohn's Disease	
☐ Diarrhea	☐ Soiling	☐ Nausea/Vomiting	☐ Irritable Bowel	
☐ Anemia	☐ Blood in Stool	☐ Hemorrhoids	☐ Screening	

MEDICATION ALLERGIES & REACTIONS:

Latex	☐ Yes	☐ No	☐ Other Allergies:	☐ Reactions:
Penicillin	☐ Yes	☐ No	_____	_____
Sulfa	☐ Yes	☐ No	_____	_____

MEDICATION COMPLETE LIST INCLUDING DOSAGE (EX. 5mg)

Aspirin	☐ Yes	☐ No	☐ Others:
Plavix	☐ Yes	☐ No	_____
Warfarin	☐ Yes	☐ No	_____

DO YOU NEED ANTIBIOTICS WITH DENTAL PROCEDURES FOR CARDIAC OR JOINT ISSUES? ☐ Yes ☐ No
CAN YOU CLIMB A FLIGHT OF STAIRS WITHOUT BECOMING WINDED? ☐ Yes ☐ No
DO YOU HAVE SLEEP APNEA OR NEED A CPAP MACHINE? ☐ Yes ☐ No

PAST HISTORY

Please check all that apply

☐ Colon Cancer	☐ IBS	☐ Hepatitis A / B / C	☐ Stroke
☐ Colon Polyps	☐ Seizures/Epilepsy	☐ COPD/ Emphysema	☐ Diabetes
☐ Diverticulitis	☐ GERD	☐ Prostate Problems	☐ Kidney Disease
☐ Crohn's Disease	☐ Stomach Ulcer	☐ Arthritis	☐ Obesity
☐ Ulcerative Colitis	☐ Gall Bladder Stones	☐ High Cholesterol	☐ Anesthesia Problems
☐ Celiac Disease	☐ Cirrhosis/Liver Disease	☐ High Blood Pressure	☐ Other Medical Problems:
		☐ Heart Disease/Failure	_____

PAST SURGICAL HISTORY

Please check all that apply

☐ Open Heart Surgery	☐ Appendectomy	☐ Upper Endoscopy
☐ Stents for the Heart	☐ Liver Biopsy	☐ Colonoscopy
☐ Hysterectomy	☐ Gastric Bypass	☐ Other Surgeries:
☐ Gall Bladder Surgery	☐ Cesarean Section	_____

FAMILY HISTORY

Please check all that apply

- ☐ Colon Polyps
- ☐ Colon Cancer
- ☐ Liver Disease
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Gallbladder Disease
- ☐ Ulcer Disease
- ☐ IBS
- ☐ Celiac Disease

Has anyone in your Family had...

Please check all that apply

- ☐ Colorectal Cancer before age 50
- ☐ Two or more Lynch Syndrome Cancers
- ☐ Ten or more lifetime Colon Polyps in the family
- ☐ Uterine Cancer before age 50
- ☐ Ovarian/Stomach/Kidney/Brain/Small Bowel Cancer
- ☐ Been tested for Hereditary Risk of Cancer

SOCIAL HISTORY

MARITAL STATUS: ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

ACTIVITY	YES	NO	How Much
Alcohol	☐	☐	
Smoker	☐	☐	
Tobacco	☐	☐	
IV Drugs (Herion, Cocaine)	☐	☐	
Other Drugs:	☐	☐	

ACTIVITY	YES	NO	How Much
Tattoos	☐	☐	
Blood Transfusions	☐	☐	
Body Piercing	☐	☐	
Dentures/Partial Plate	☐	☐	
Glasses/ Contacts	☐	☐	

VACCINATIONS **HEPATITIS A.** ☐ Yes ☐ No **HEPATITIS B** ☐ Yes ☐ No

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REVIEW OF SYSTEMS: Please examine the symptoms listed below and check any that currently apply.

Constitutional
- ☐ Chills
- ☐ Fever
- ☐ Fatigue
- ☐ Weight Loss

HEENT
- ☐ Double Vision
- ☐ Ear Infections
- ☐ Eye Pain
- ☐ Nasal Congest.
- ☐ Sinus Infection
- ☐ Sore Throat

Respiratory
- ☐ Short of Breath
- ☐ Frequent Cough
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pains
- ☐ Extremity Pains
- ☐ Palpitations

Genitourinary
- ☐ Pain Urinating
- ☐ Blood in Urine
- ☐ Frequently Urination
- ☐ Urine Incontinence
- ☐ Urine Retention

Neurological
- ☐ Dizziness
- ☐ Headache
- ☐ Numbness
- ☐ Tremors

Metabolic/Endocrine
- ☐ Cold Intolerance
- ☐ Excessive Thirst
- ☐ Heat Intolerance

Psychiatry
- ☐ Anxiety
- ☐ Depression
- ☐ Increased Stress

Musculoskeletal
- ☐ Back Pain
- ☐ Muscle Pain
- ☐ Joint Pain

Hematologic
- ☐ Bleed Easy
- ☐ Bruise Easy

Reproductive
- ☐ Breast Lumps
- ☐ Breast Pain
- ☐ Vaginal Discharge

Integument
- ☐ Contact Allergy
- ☐ Hives
- ☐ Itching
- ☐ Rash

Immunologic
- ☐ Asthma
- ☐ Chemicals
- ☐ Food Allergies
- ☐ Poor Immunity

Please provide your signature and date stating that you have filled this form out as accurately as possible.

Type your full name and date below as your digital signature.

Save and email your completed form to gastro@springfieldgastro.com.

_____ _____

Signature of Patient/Guardian/ Employee Obtaining Information **Date**