

Gastrointestinal Specialists

PART I TO BE COMPLETED BY PATIENT

Date: _____ Phone: _____

Name: _____ Date of Birth: _____

Reason for Visit: _____

PLEASE CHECK IF YOU OR A FAMILY MEMBER HAS HAD ANY OF THE FOLLOWING ILLNESSES:

(If a family member, please indicate father, mother, sister, etc., under "who")

- | Who | Who |
|---|--|
| <input type="checkbox"/> Ulcerative Colitis _____ | <input type="checkbox"/> Celiac Sprue _____ |
| <input type="checkbox"/> Ulcer Disease _____ | <input type="checkbox"/> Liver Disease _____ |
| <input type="checkbox"/> Colonic Polyps _____ | <input type="checkbox"/> Crohn's Disease _____ |
| <input type="checkbox"/> Colonic Carcinoma _____ | |

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE EXPERIENCED DURING THE LAST YEAR:

- | | | |
|---|--|---|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Lump in Breast |
| <input type="checkbox"/> Change in Vision | <input type="checkbox"/> Constipation | <input type="checkbox"/> Nipple Discharge |
| <input type="checkbox"/> Change in Hearing | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Gum or Mouth Pain | <input type="checkbox"/> Urination Difficulty | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Numbness | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Tremor | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Skin Changes | <input type="checkbox"/> Joint Pain / Swelling | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Fever / Chills |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Lightheadedness |
| <input type="checkbox"/> Chest Pain / Tightness | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Leg Swelling / Pain | <input type="checkbox"/> Increased Thirst | <input type="checkbox"/> Depression |

- Do you smoke? Yes No If yes, how much: _____
- Do you use alcohol? Yes No If yes, how much: _____
- Do you use drugs? Yes No _____
- Do you drink coffee or tea? Yes No If yes, how much: _____
- What is your occupation? _____

(Patient Signature)