Digestive Disease Associates

6400 W. Newberry Road, Suite 302 Gainesville, FL 32605 Phone: (352)-331-8902 *Visit our website at: www.GainesvilleGl.com*

Please fill out the following form completely so that we may obtain the necessary information for our files and background information on your medical problem. In this way, more time will be available for you to talk to the doctor at the time of your visit.

All information is held in <u>strict confidence</u> and will NOT be released to anyone without your written consent.

atient ID Number: (for office use)		Referring Physician:			
imary Care Physician:		Phone Nun	Number: ()		
me:	st Middle	Da	ate of Birth:Age:		
iling Address: Street City	State	Se Zip	ex: Race:Ethnicity:		
me Phone: ()	Cell Phone: (_)	SSN:		
ken Language:	Birth	olace: (State or Count	try)		
ferred Method of Contact:		Email Address:			
cupation:	Employer:		Work Phone:()		
son to notify in case of emergend	cy:	Relationship:	Phone Number: ()		
ured information:		Insured DOB:	Insured SSN:		
(If different from aburance Company:(1)	oove)	(2)			
n 1 ID Number:		Plan 2 ID Number:			
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HAT MEDICAL PROBE	TART?	WHERE?	E DOCTOR TODAY?		
HAT MEDICAL PROBING THAT DATE DID THE SYMPTOMS STATEMENT HAT MAKES THE SYMPTOMS WOLL EVIOUS TREATMENT: EMERGENCY ROOM: DOCTOR'S OFFICE: LLERGIES: Please check	TART?	WHERE?	■ No known drug allergies		

CHECK ALL DISEASES THAT HAVE OCCURED IN YOUR FAMILY and INDICATE FAMILY MEMBER **AFFECTED** (mother, father, sister, brother, grandparents, etc.)

Anemia	Breast Cancer	Cirrhosis of Liver	Colon Polyps	Colorectal Cancer
Crohn's Disease	Diabetes, (takes pills)	Diabetes, Insulin Dependant	Gastric Cancer	Gallstones
Heart Disease	Hemochromatosis	Irritable Bowel Syndrome	Liver Disease	Gynecological Ca
Pancreatic Cancer	Acute Pancreatitis	Chronic Pancreatitis	Peptic Ulcer Disease	Ulcerative Colitis
Other:	, route r arror outline	- Children Carlot Sallino		0.001.001.00

CANCER Colon Cancer Cervical Cancer Esophageal Cancer Breast Cancer Breast Cancer Endometrial Cancer (uterus) Liver Cancer Leukemia Lymphoma Kidney Stones Kidney Failure Dialysis MUSCULOSKELETAL Fibromyalgia OsteoArthritis Raynaud's Rehumatic Fever Heart Valve Disease Endocarditis Raynaud's Scleroderma Gout BLOOD Scleroderma Gout BLOOD Anxiety Depression Oobsessive Compulsive Disorder Schizophrenia LIVER Hemochromatosis Cirrhosis Hepatitis A Hepatitis B Hepatitis C Jaundice Selizures Migraines Other Headache RESPIRATORY COPD (Emphysema) Asthma Tuberculosis (TB) Sleep Apnea Collapsed Lung GASTROINTESTINAL IBS-Irritable Bowel Syndrome Diverticulitis Diverticulitis Diverticulisis Peptic Ulcer Disease Angiodysplasia of GI tract Reflux IBD-Crohn's IBD-Ulcerative Colitis Pancreatitis Barrett's Esophagus Colon Polyps ENDOCRINOLOGY Diabetes, Type I (insulin needed) Diabetes, Type I (insulin needed) Thyroid Disease	PAST MEDICAL HISTORY: Do	YOU now, or have YOU ever had any of the	following illnesses, check all that apply.
Cervical Cancer Esophageal Cancer Breast Cancer Breast Cancer Pancreatic Cancer Endometrial Cancer (uterus) Liver Cancer Leukemia Lymphoma Heart Attack (Myocardial Infarction) Lymphoma Kidney Failure Dialysis MUSCULOSKELETAL Fibromyalgia Osteo Arthritis Reumatoid Arthritis Raynaud's Raynaud's Sjogrens Scleroderma Gout PSYCHOLOGICAL Bipolar Anxiety Depression Obsessive Compulsive Disorder Schizophrenia Stepattis A Hepatitis A Hepatitis A Hepatitis B Hepatitis C Coffer (Hepatitis B Hepatitis C Hepatitis B Hepatitis B Hepatitis B Hepatitis B Hepatitis B Hepatitis B Hepatitis C CoPD (Emphysema) Astma Tuberculosis (TB) Sleep Apnea Gostlep Apnea Lollege Apnea Lollege Apnea Lollege Apnea Lollege Apnea LiBS-Irritable Bowel Syndrome Diverticulosis Diverticulosis Poicritable Ever Hest T Liver Astma Tuberculosis (TB) Sleep Apnea Lollege Ap			NEUROLOGICAL
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SchizophreniaMelanoma			
	Schizophrenia		
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SURGERIES and PROCEDURES: INDICATE THE DATE OF ANY SURGERIES YOU HAVE HAD

GASTROINTESTINALAppendectomyHiatal Hernia RepairCholecystectomy (Gallbladder Removal)	GYNECOLOGICAL Hysterectomy (Uterus Removed) Ovary Removal (Oopherectomy) RightLeftBoth C-Section	CARDIAC Heart Stent placed CABG (Coronary Bypass) Abdominal Aneurysm repair FemPop Bypass (Leg Arteries)
Surgery for Intestinal Adhesions Gastric Bypass	Mastectomy (Breast Surgery)RightLeft Both	Heart Valve replacement
Colon Surgery, partial Gastric Surgery Splenectomy (removal of spleen) Hernia Type: Colonoscopy Upper Endoscopy (EGD) ERCP Pancreatic Surgery	GUTURPBladder SurgeryCystectomy with Ileal conduitKidney Removal (nephrectomy)Prostate Removal (prostatectomy)Radiation for prostate cancer	OTHER Thyroidectomy (Thyroid Surgery) Glaucoma Surgery Cataract Surgery

LICTAL

7 you live	with Family _	Other:		
eligion:		Marital Status: Mar	rried Single	e Widowed Divorced
ease indicate TOBACCO USE:	None			
Cigarettes:packs per da	ay	years of use	Quit:	(please list year)
Other (Cigar/Snuff)frequency/da	ay	years of use	Quit:	(please list year)
ease indicate ALCOHOL USE:	None			
w many glasses/cans do you drink	daily	wee	kly	occasionally
you have a history of alcoholism or heavy EVIEW OF SYSTEMS	alcohol intake? _	yesno		
	disease diagnosed du		(Items left blan	k indicate a negative response) NEUROLOGICAL
Loss of Appetite/Anorexia Fatigue Fever Night Sweats Weight gain in the last 3 months Amount Weight loss in the last 3 months Amount	Blood ir Painful Painful Frequer Urgence Do you stimula RESPIRATORY	n urine urination nt urination y with urination have a implanted blactor?	dder	Difficulty SpeakingFocal Neurological SymptomsSyncopeIncontinence UrineIncontinence StoolSeizure
Are you under any stress? KKIN Puritis/Itching Skin Rash	CARDIOVAS Chest F Claudic Edema/	CULAR Pain ations /Swelling		Feel scared or anxious Depression Feel like crying for no reason Insomnia/Trouble Sleeping
ENT Headache Eye Pain Eye Redness Visual Loss Nasal inflammation Nose bleed(s) Bleeding gums Hoarseness Oral Ulcers	Palpitat Sleep A Shortne Conges Myocan Valve R	pnea ess of Breath tive Heart Failure dial Infarction eplacement have a Pacemaker? have an implanted de		GASTROINTESTINAL Frequent constipation Pain with bowel movement Pale, greasy, oily or rancid stools Mucus in or on your stool Frequent diarrhea Black or sticky stools Blood in or on your stools Vomit frequently Vomit blood or "coffee grounds" Bloating, belching or excessive ga Difficult or painful swallowing Frequent heartburn or indigestion Frequent stomach pain

Please indicate if you have had the following immunizations:					
Influenza (yearly)	Date:	Hepatitis A	Date:		
Pneumonia Vaccine	Date:	Hepatitis B Series	Date:		
Zostavax	Date:				

PATIENT MEDICATION LIST

Name:	MR#:	Date:
ALLERGIES:		

PLEASE PRINT !!!! Medication List should include all OTC and PRN medications.

Medication Name	Strength	# of times taken daily	Reason	Team Leader's Initials	Date
EXAMPLE: Prilosec	20 mg	1 QD	GERD	ALH	03/07/2002

Medication List Reviewed:

Physician Signature

Date