Digestive Disease Associates

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Visit our website at: www.GainesvilleGI.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 **strict confidence** and will NOT be released to anyone without your written consent.*

PATIENT INFORMATION-*Please print all information*

Date:_____

Patient ID Number: _____ (for office use) Referring Physician:_____

Primary Care Physician:_____ Phone Number: (_____)_____

Name:_____ Date of Birth:_____ Age:_____
Last First Middle mm/dd/yy

Mailing Address:_____ Sex:____ Race:_____Ethnicity:_____
Street City State Zip

Home Phone: (____)_____ Cell Phone: (_____)_____SSN: _____

Spoken Language:_____ Birthplace: (State or Country)_____

Preferred Method of Contact:_____ Email Address:_____

Occupation:_____ Employer:_____ Work Phone:(____)_____

Person to notify in case of emergency:_____Relationship:_____ Phone Number: (____)_____

Insured information:_____Insured DOB:_____Insured SSN:_____
(If different from above)

Insurance Company:(1)_____(2)_____

Plan 1 ID Number:_____ Plan 2 ID Number: _____

Plan 1 Group Number:_____Plan 2 Group Number:_____

WHAT MEDICAL PROBLEM BROUGHT YOU TO SEE THE DOCTOR TODAY?

_____

_____

WHAT DATE DID THE SYMPTOMS START?_____

WHAT MAKES THE SYMPTOMS BETTER?_____

WHAT MAKES THE SYMPTOMS WORSE?_____

PREVIOUS TREATMENT:

EMERGENCY ROOM: _____YES _____NO **WHERE?**_____

DOCTOR'S OFFICE: _____YES _____NO **WHERE?**_____

ALLERGIES: Please check any allergies that apply to you

❑No known drug allergies

Are you allergic to: ❑Latex ❑Penicillin ❑Sulfa ❑ Iodine ❑Tetanus ❑Other:_____

What are the complications from your allergy:

❑Nausea ❑Hives ❑Rash ❑Swollen Throat ❑Difficulty Breathing ❑Other: _____

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:				

PAST MEDICAL HISTORY: Do ***YOU*** now, or have ***YOU*** ever had any of the following illnesses, check all that apply.

CANCER
_____Colon Cancer
_____Cervical Cancer
_____Esophageal Cancer
_____Stomach Cancer
_____Breast Cancer
_____Pancreatic Cancer
_____Endometrial Cancer (uterus)
_____Liver Cancer
_____Leukemia
_____Lymphoma

RENAL
_____Kidney Stones
_____Kidney Failure
_____Dialysis

MUSCULOSKELETAL
_____Fibromyalgia
_____OsteoArthritis
_____Rheumatoid Arthritis
_____Raynaud's
_____Lupus
_____Sjogrens
_____Scleroderma
_____Gout

PSYCHOLOGICAL
_____Bipolar
_____Anxiety
_____Depression
_____Obsessive Compulsive Disorder
_____Schizophrenia

LIVER
_____Hemochromatosis
_____Cirrhosis
_____Hepatitis A
_____Hepatitis B
_____Hepatitis C
_____Jaundice
_____Fatty Liver

HEART
_____High Blood Pressure (Hypertension)
_____Heart Attack (Myocardial Infarction)
_____Angina
_____Congestive Heart Failure
_____Palpitations
_____Mitral Valve Prolapse
_____Elevated Triglycerides
_____Elevated Cholesterol
_____Rheumatic Fever
_____Heart Valve Disease
_____Endocarditis
_____Abnormal Heart Rhythm

BLOOD
_____VonWillebrands'
_____Hemophillia
_____Bleeding or clotting abnormalities
_____Anemia

INTEGUMENTARY
_____Eczema
_____Skin Cancer
_____Melanoma
_____Psoriasis

NEUROLOGICAL
_____Stroke
_____Seizures
_____Migraines
_____Other Headache

RESPIRATORY
_____COPD (Emphysema)
_____Asthma
_____Tuberculosis (TB)
_____Sleep Apnea
_____Collapsed Lung

GASTROINTESTINAL
_____IBS-Irritable Bowel Syndrome
_____Diverticulitis
_____Diverticulosis
_____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 II (pills needed)
_____Thyroid Disease

SURGERIES and PROCEDURES: INDICATE THE DATE OF ANY SURGERIES YOU HAVE HAD

GASTROINTESTINAL
_____Appendectomy
_____Hiatal Hernia Repair
_____Cholecystectomy
(Gallbladder Removal)
_____Surgery for Intestinal
Adhesions
_____Gastric Bypass
_____Colon Surgery, partial
_____Gastric Surgery
_____Splenectomy (removal of spleen)
_____Hernia Type:_____
_____Colonoscopy
_____Upper Endoscopy (EGD)
_____ERCP
_____Pancreatic Surgery

GYNECOLOGICAL
_____Hysterectomy (Uterus Removed)
_____Ovary Removal (Oopherectomy)
_____Right _____Left _____Both
_____C-Section
_____Mastectomy (Breast Surgery)
_____Right _____Left _____ Both

GU
_____TURP
_____Bladder Surgery
_____Cystectomy with Ileal conduit
_____Kidney Removal (nephrectomy)
_____Prostate Removal (prostatectomy)
_____Radiation for prostate cancer

CARDIAC
_____Heart Stent placed
_____CABG (Coronary Bypass)
_____Abdominal Aneurysm repair
_____FemPop Bypass (Leg Arteries)
_____Heart Valve replacement

OTHER
_____Thyroidectomy (Thyroid Surgery)
_____Glaucoma Surgery
_____Cataract Surgery

SOCIAL HISTORY

Do you live: _____Alone _____with Family _____Other:_____

Religion:_____ Marital Status: *Married* *Single* *Widowed* *Divorced* _____

Please indicate **TOBACCO USE**: _____None

_____Cigarettes: _____packs per day _____years of use Quit: _____(please list year)

_____Other (Cigar/Snuff)_____frequency/day _____years of use Quit: _____(please list year)

Please indicate **ALCOHOL USE:** _____None

How many glasses/cans do you drink _____daily _____weekly _____occasionally

Do you have a history of alcoholism or heavy alcohol intake? _____yes _____no

REVIEW OF SYSTEMS

*Please check any symptom or disease diagnosed during the **last 2 months** (Items left blank indicate a negative response)*

GENERAL
_____Loss of Appetite/Anorexia
_____Fatigue
_____Fever
_____Night Sweats
_____Weight gain in the last 3 months
Amount_____
_____Weight loss in the last 3 months
Amount_____
_____Are you under any stress?

SKIN
_____Puritis/Itching
_____Skin Rash

ENT
_____Headache
_____Eye Pain
_____Eye Redness
_____Visual Loss
_____Nasal inflammation
_____Nose bleed(s)
_____Bleeding gums
_____Hoarseness
_____Oral Ulcers
_____Voice Changes

HEMATOLOGY
_____Enlarged Lymph Nodes
_____Prolonged Bleeding

GENITOURINARY
_____Blood in urine
_____Painful urination
_____Frequent urination
_____Urgency with urination
_____Do you have a implanted bladder stimulator?

RESPIRATORY
_____Cough
_____Shortness of Breath
_____Wheezing

CARDIOVASCULAR
_____Chest Pain
_____Claudications
_____Edema/Swelling
_____Difficulty breathing while laying down
_____Palpitations
_____Sleep Apnea
_____Shortness of Breath
_____Congestive Heart Failure
_____Myocardial Infarction
_____Valve Replacement
_____Do you have a Pacemaker?
_____Do you have an implanted defibrilator?

ENDOCRINE
_____Extreme thirst
_____Frequent Urination

NEUROLOGICAL
_____Difficulty Speaking
_____Focal Neurological Symptoms
_____Syncope
_____Incontinence Urine
_____Incontinence Stool
_____Seizure

PSYCHIATRIC
_____Feel scared or anxious
_____Depression
_____Feel like crying for no reason
_____Insomnia/Trouble Sleeping

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 gas
_____Difficult or painful swallowing
_____Frequent heartburn or indigestion
_____Frequent stomach pain
_____Recent changes in your bowel movement
_____Jaundice (yellow eyes)

IMMUNIZATIONS

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