Date of appointment: _____

Patient name: _____ Date of birth: _____ Age: _____

Primary care provider: _____ Referring provider: _____

Reason for Visit Today (Select all that apply):

☐	Abdominal Distention	☐	Abdominal Pain	☐	Rectal Bleeding	☐	Blood in Stool	☐	Constipation
☐	Diarrhea	☐	Nausea	☐	Rectal Pain	☐	Vomiting	☐	Trouble Swallowing
☐	Incontinence	☐	Heartburn	☐	Acid Reflux (GERD)	☐	Crohn's Disease	☐	Irritable Bowel Syndrome
☐	Inflammatory Bowel Disease	☐	Ulcerative Colitis	☐	Achalasia	☐	Barrett's Esophagus	☐	Eosinophilic esophagitis
☐	Other								

To be filled out by nurse:

Preferred local pharmacy: _____ **Preferred mail order pharmacy:** _____

Preferred laboratory for blood work: _____ **Preferred radiology facility:** _____

HT _____ **Weight** _____ **BP** _____/_____ **Pulse** _____ **Temp** _____

Immunizations: **Flu / When** ☐ / _____ **(65 or older) Pneumovax/When** ☐ / _____

Fallen within the last 3 months? Yes ☐ **No** ☐ **Fear of falling? Yes** ☐ **No** ☐ **Difficulty ambulating? Yes** ☐ **No** ☐

Patient Review of Systems

Please mark any conditions with which you have had symptoms in the last 2 weeks:

	Constitutional
☐	Appetite Change
☐	Fatigue
☐	Fever
☐	Unexpected Weight Change
	HENT
☐	Trouble swallowing
☐	Sore throat
	Eyes
☐	Vision problems
	Respiratory
☐	Apnea
☐	Cough
☐	Shortness of Breath
	Cardiovascular
☐	Irregular Heart Beat
☐	Chest Pain

	Gastrointestinal
☐	Abdominal bloating
☐	Abdominal pain
☐	Rectal Bleeding
☐	Blood in stool
☐	Constipation
☐	Diarrhea
☐	Nausea
☐	Rectal Pain
☐	Vomiting
☐	
	Genitourinary
☐	Painful Urination
	Musculoskeletal
☐	Joint pain
☐	Back Pain
☐	Trouble Walking

	Skin
☐	Skin Color Changes?
☐	Rash?
	Neurological
☐	Light-headedness
☐	Seizures
☐	Headaches
	Hematologic
☐	Swollen Glands
	Behavioral Health
☐	Nervous/Anxious
☐	Sleep Problems

Patient name: _____ Date of birth: _____

GI Medical History:

	Y	Year diagnosed & Treatment received		Y	Year diagnosed & Treatment received
Colon cancer			Cirrhosis		
Colon polyps			Irritable bowel syndrome		
Ulcerative Colitis			Pancreatic cancer		
Gallbladder stones			Celiac Disease		
Acid reflux			Liver disease		
Diverticular disease			Rectal cancer		
Chronic constipation			Crohn's disease		
Hernia			Pancreatitis		
Esophageal cancer			Small intestine cancer		
Chronic diarrhea			Diverticulitis		
Hepatitis			Peptic ulcer		
Liver cancer			Stomach cancer		

Patient Medical History

Please mark ALL conditions which apply to you, the year diagnosed, and any treatment received:

	Y	Year diagnosed & treatment received		Y	Year diagnosed & treatment received
Thyroid disease			Glaucoma		
COPD / chronic bronchitis			Seizures		
Kidney disease			Cancer		
Anemia			Heart problems		
Depression			Stroke		
Nerve / muscle disease			Cataracts		
Anxiety			HIV/AIDS		
Diabetes mellitus			Substance Abuse		
Brittle bones (osteoporosis)			Bleeding problem		
Arthritis			High blood pressure		

Patient GI Surgical/Procedure History

Please mark ALL that apply with dates of GI surgeries/procedures:

Surgery/Procedure	Y	Date of surgery/ procedure	Surgery/Procedure	Y	Date of surgery/ procedure
Previous Surgeries			Colonoscopy		
Appendectomy			Stomach surgery for reflux		
ERCP procedure			Gall bladder removal		
Liver biopsy			Ultrasound during GI scope		
Colon/large intestine surgery			Liver surgery		
Polyp removal			Colostomy		
Small intestine surgery			Sigmoidoscopy		
Esophagus surgery			Stoma closure, Large Bowel		
Small Bowel Scope			Gastric Bypass		
Stomach surgery			Upper GI endoscope		

Patient name: _____ Date of birth: _____

Please mark ALL that apply and dates of any surgeries:

	Y	Date of surgery		Y	Date of surgery
Brain surgery			Fracture surgery		
Prostate surgery			Heart surgery		
Spine surgery			Hernia repair		
Plastic surgery			Heart valve replacement		
Eye surgery			Joint replacement		
Vasectomy					

Family History

Indicate if any blood relative has the following. (Please note which relative and if it's maternal or paternal)

Condition	Relative	Name	Comments
Colorectal Cancer			
Colon polyps			
Celiac disease			
Cirrhosis			
Cholangiocarcinoma			
Crohn's disease			
Cystic Fibrosis			
Esophageal cancer			
Gallbladder and bile duct cancer			
Gastric cancer			
Hemochromatosis			
Inflammatory bowel disease			
Irritable bowel syndrome			
Liver cancer			
Liver disease			
Pancreatic cancer			
Pancreatitis chronic			
Rectal cancer			
Stomach cancer			
Ulcerative colitis			
Wilson's disease			

Patient name: _____ Date of birth: _____

Tobacco Use History

Current Everyday smoker	Current Some Day Smoker	Never	Former smoker	Passive Smoker	Heavy Smoker	Light Smoker
☐	☐	☐	☐	☐	☐	☐

Comments on your history with tobacco:

Social History

Alcohol Use

☐ Yes ☐ Not Currently ☐ Never

Drug Use

☐ Yes ☐ Not Currently ☐ Never

Sexually Active

☐ Yes ☐ Not Currently ☐ Never

Medications (please list if not attached):

Medication Name	Dose	Frequency

Medication Allergies (if any):

Name of allergen	Reaction/Date of Onset