Ata Moshyedi, MD. Radman Mostaghim, MD, PhD. Sushil Rattan, MD.
GASTROENTEROLOGY

Please fill out the information below to the best of your knowledge

Patient Name: _____ Birth Date: _____

Chief complain/reason for visit: _____

Past Medical History

Have you ever had the following:

Measles……no yes	Glaucoma …… no yes	Back problems……no yes	Thyroid disease … . no yes
Mumps…… no yes	Bladder infection….. no yes	High Blood pressure.. no yes	Kidney Disease.. ….no yes
Chicken pox…… no yes	Epilepsy…….. no yes	High cholesterol …… no yes	Colitis ……..…… no yes
Whooping cough…. no yes	Migraine Headache. no yes	Bleeding tendency.. no yes	Bleeding Hemorrhoids no yes
Scarlet Fever……no yes	Heart attack …… no yes	Hives or eczema ……no yes	Colon polyp……no yes
Diphtheria……no yes	Heart failure …….. no yes	Asthma / COPD … .. no yes	Stomach ulcer ……..no yes
Smallpox…… no yes	Slow heart rate …. no yes	MASA infection …… no yes	Cancer _____
AIDS or HIV+….. no yes	Diabetes ……no yes	PVD …… no yes	_____
Rheumatic fever…. no yes	Anemia…… no yes	Stroke…… no yes	Other: _____
Tuberculosis …….. no yes	Blood transfusion …no yes	Cirrhosis of liver …... no yes	_____
Polio …….. no yes	Heart burn …… no yes	Hepatitis B …… no yes	**Date of last colonoscopy:**
Venereal Disease…. no yes	Arthritis ……. no yes	Hepatitis C…… no yes	_____

Medications, including dose and frequency: (Include Herbal and OTC non prescription)

_____

_____

_____

Allergies (Drug and food): _____

Any Latex allergy _____ Any allergy to egg, soy protein or peanut? _____

Previous Serious illness required hospitalizations: _____ (illness) _____ (Hosp) _____ yr

Surgical History: ? ☐ Brain surgery ☐ Facial reconstruction ☐ Jaw surgery ☐ Thyroid removed ☐ Lung surgery ☐Gastric Bypass ☐Esophagus surgery ☐ Colon resection ☐ Appendix removed ☐ Gall bladder removed ☐ stomach removed ☐ Left/Right Mastectomy ☐Knee Arthroscopy ☐ Hip Replacement Left or Right ☐ Prostate surgery ☐ Heart surgery

Other surgery:_____

Last menstrual period: _____ Are you pregnant: _____ # of pregnancies _____ # of abortion _____ # of miscarriage _____

Patient Social History: Occupation: _____

Excessive exposure at home or work to ☐ Fumes ☐ Dust ☐ Solvents ☐ Air-borne particles ☐ Noise

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow

Use of Alcohol ☐ Never ☐ Rarely ☐ Moderate ☐ Daily ☐ wine ☐ beer ☐ liquor

Use of tobacco ☐ Never ☐Previously, but quit ____ yrs ago, ____ yrs smoking history _____pack per day.
☐ Current, packs per day: _____ for _____ years.

Use of drugs ☐ Never ☐recreation drug user Type/Frequency: _____ Last use on_____

Family Medical History: Check and circle all applied.

☐ Family history of **colon cancer** (Father / Mother / Siblings / Grandparents / Spouse / Children / relatives _____)
Age of disease onset_____ , If deceased, cause of death:_____

☐ Family history of **stomach cancer** (Father / Mother / Siblings / Grandparents / Spouse / Children / relatives _____) Age of disease onset_____ , If deceased, cause of death:_____

☐ Family history of **pancreatic / bile duct cancer** (Father / Mother / Siblings / Grandparents / Spouse / Children / relatives _____) Age of disease onset_____ , If deceased, cause of death:_____

☐ Family history of **Liver cancer or disease / Hepatitis B or C** (Father / Mother / Siblings / Grandparents / Spouse / Children / relatives _____) Age of disease onset_____ , If deceased, cause of death:_____

☐ Family history of **Crohn's disease** (Father / Mother / Siblings / Grandparents / Spouse / Children / relatives _____) Age of disease onset_____ , If deceased, cause of death:_____

☐ Family history of **ulcerative colitis** (Father / Mother / Siblings / Grandparents / Spouse / Children / relatives _____) Age of disease onset_____ , If deceased, cause of death:_____

☐ Family history of _____ (Father / Mother / Siblings / Grandparents / Spouse / Children / relatives _____) Age of disease onset_____ , If deceased, cause of death:_____

Ata Moshyedi, MD. Radman Mostaghim, MD, PhD. Sushil Rattan, MD.
GASTROENTEROLOGY

Review of systems: Please indicate any personal history below:

Constitutional symptoms

Good general health lately ….no yes
Recent weight change…….no yes
Fever……no yes
Fatigue……....no yes
Headaches……...no yes

Eyes

Eye disease or injury…….. …no yes
Wear glasses/contact lenses… ….no yes
Blurred or double vision…….no yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing…. …..no yes
Earaches or drainage…… …..no yes
Chronic sinus problems/
Rhinitis……no yes
Nose bleeds…….……no yes
Mouth sores……no yes
Bleeding gums……. …...no yes
Bad breath/bad taste……no yes
Sore throat/voice change…….no yes
Swollen glands in neck……...no yes

Cardiovascular

Heart problems……no yes
Chest pain/angina pectoris…..no yes
Palpitation…… ..no yes
Shortness of breath w/walking
Or lying flat……. ...no yes
Swelling of the feet/ankles/feet. ..no yes

Respiratory

Do you have a persistent cough or
Throat clearing not associated with a
Known illness (lasting more than 3
wks)……..…no yes
Spitting up blood……..…no yes
Shortness of breath……..no yes
Wheezing……no yes

Gastrointestinal

Loss of appetite……...no yes
Change in bowel movements…...no yes
Nausea or vomiting……no yes
Frequent diarrhea……no yes
Painful bowel movements…...no yes
Constipation……no yes
Rectal bleeding/blood in stool…..no yes
Abdominal pain……...no yes
Black / tarry stool……no yes

Genitourinary

Frequent urination……...no yes
Burning or painful urination...no yes
Blood in urine……..no yes
Change in force of strain when
Urinating……no yes
Incontinence or dribbling……no yes
Kidney stones……..…no yes
Sexual difficulty……..no yes
Male-testicle pain……no yes
Female-pain with periods……no yes
Female-irregular periods…….no yes
Female- vaginal discharge…..no yes
Female-date of last pap smear:
_____

Musculoskeletal

Joint pain……no yes
Joint stiffness or swelling…...no yes
Weakness or muscles or joints….no yes
Muscle pain or cramps……no yes
Back pain……no yes
Cold extremities……..no yes
Difficulty in walking……...no yes

Integumentary (skin, breast)

Rash or itching……no yes
Change in skin color……...no yes
Change in hair or nails……no yes
Varicose veins……no yes
Breast pain……...no yes
Cold extremities……..no yes
Difficulty in walking……. .no yes

Integumentary (skin, breast)

Rash or itching……no yes
Change in skin color……...no yes
Change in hair or nails……no yes
Varicose pain……..no yes
Breast pain……..no yes
Breast lump……no yes
Breast discharge……..no yes

Neurological

Frequent or recurrent headache…no yes
Light headed or dizzy……..no yes
Convulsions or seizure……no yes
Numbness or tingling sensation…no yes
Tremors……...no yes
Paralysis……..no yes
Head injury……..no yes

Psychiatric

Memory loss or confusion…...no yes
Nervousness……no yes
Depression……...no yes
Insomnia……..no yes

Endocrine

Glandular or hormone problem…no yes
Excessive thirst or urination….no yes
Heat or cold intolerance……..no yes
Skin becoming dryer……...no yes
Change in hat or glove size….no yes

Hematologic/lymphatic

Slow to heal after cut……..no yes
Bleeding or bruising tendancies..no yes
Anemia……no yes
Phlebitis……...no yes
Past transfusion……...no yes
Enlarged glands……...no yes

Allergic/immunologic

History of skin reaction or other
adverce reaction to:
Latex …… no yes
Penicillin or other antibiotics..no yes
Morphine, Demerol, or
other narcotic……...no yes
Novocain or other anesthetic…...no yes
Aspirin or other pain remedies….no yes
Tetanus antitoxin or other
Serums……no yes
Iodine, Merthiolate …… no yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the Doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ Signature of Patient/parent/or legal guardian _____ Date

Doctor's Review

_____ Physician's signature _____ Review date
_____ Physician's signature _____ Review date