

PATIENT NAME _____

DATE OF BIRTH _____

PATIENT'S AGE _____

REFERRED BY _____

1. DESCRIBE YOUR CURRENT PROBLEM(S).

- A. _____
- B. _____

2. H.P.I.

A. Heartburn	<input type="checkbox"/> Y	<input type="checkbox"/> N	N. Gallbladder Problems	<input type="checkbox"/> Y	<input type="checkbox"/> N
B. Trouble Swallowing	<input type="checkbox"/> Y	<input type="checkbox"/> N	O. Diarrhea	<input type="checkbox"/> Y	<input type="checkbox"/> N
C. Painful Swallowing	<input type="checkbox"/> Y	<input type="checkbox"/> N	P. Constipation	<input type="checkbox"/> Y	<input type="checkbox"/> N
D. Nausea/Vomiting	<input type="checkbox"/> Y	<input type="checkbox"/> N	Q. Change in bowel habit	<input type="checkbox"/> Y	<input type="checkbox"/> N
E. Pain/Burning in stomach	<input type="checkbox"/> Y	<input type="checkbox"/> N	R. Weight loss	<input type="checkbox"/> Y	<input type="checkbox"/> N
F. History of ulcers	<input type="checkbox"/> Y	<input type="checkbox"/> N	S. Fever	<input type="checkbox"/> Y	<input type="checkbox"/> N
G. Vomit blood	<input type="checkbox"/> Y	<input type="checkbox"/> N	T. Lack of appetite	<input type="checkbox"/> Y	<input type="checkbox"/> N
H. Bloody stools	<input type="checkbox"/> Y	<input type="checkbox"/> N	U. Family history of polyps	<input type="checkbox"/> Y	<input type="checkbox"/> N
I. Anemia (low blood count)	<input type="checkbox"/> Y	<input type="checkbox"/> N	V. Family history of cancer of colon	<input type="checkbox"/> Y	<input type="checkbox"/> N
J. Hepatitis	<input type="checkbox"/> Y	<input type="checkbox"/> N	W. Family history of ulcers	<input type="checkbox"/> Y	<input type="checkbox"/> N
K. Jaundice	<input type="checkbox"/> Y	<input type="checkbox"/> N	X. Family history of colitis	<input type="checkbox"/> Y	<input type="checkbox"/> N
L. Liver problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Y. Family history of gallstones	<input type="checkbox"/> Y	<input type="checkbox"/> N
M. Pancreas Problems	<input type="checkbox"/> Y	<input type="checkbox"/> N			

3. PAST HISTORY

	<i>year & comment</i>		<i>year & comment</i>
A. SURGICAL HISTORY		hysterectomy	<input type="checkbox"/> Y <input type="checkbox"/> N _____
appendectomy	<input type="checkbox"/> Y <input type="checkbox"/> N _____	ovaries removed	<input type="checkbox"/> Y <input type="checkbox"/> N _____
breast surgery	<input type="checkbox"/> Y <input type="checkbox"/> N _____	joint replacement	<input type="checkbox"/> Y <input type="checkbox"/> N _____
colon surgery	<input type="checkbox"/> Y <input type="checkbox"/> N _____	stomach surgery	<input type="checkbox"/> Y <input type="checkbox"/> N _____
gallbladder surgery	<input type="checkbox"/> Y <input type="checkbox"/> N _____	thyroid surgery	<input type="checkbox"/> Y <input type="checkbox"/> N _____
heart and/or bypass	<input type="checkbox"/> Y <input type="checkbox"/> N _____	tonsillectomy	<input type="checkbox"/> Y <input type="checkbox"/> N _____
hemorrhoidectomy	<input type="checkbox"/> Y <input type="checkbox"/> N _____	other surgery (write in if not listed)	_____
hernia repair	<input type="checkbox"/> Y <input type="checkbox"/> N _____		

B. MEDICAL HISTORY:

hepatitis	<input type="checkbox"/> Y	<input type="checkbox"/> N	psychiatric	<input type="checkbox"/> Y	<input type="checkbox"/> N
other liver disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	diabetic	<input type="checkbox"/> Y	<input type="checkbox"/> N
lung disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	glaucoma	<input type="checkbox"/> Y	<input type="checkbox"/> N
heart disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	enlarged prostate	<input type="checkbox"/> Y	<input type="checkbox"/> N
high blood pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N	thyroid disorder	<input type="checkbox"/> Y	<input type="checkbox"/> N
stomach/intestine	<input type="checkbox"/> Y	<input type="checkbox"/> N	high cholesterol	<input type="checkbox"/> Y	<input type="checkbox"/> N
seizure	<input type="checkbox"/> Y	<input type="checkbox"/> N	other (write in if not listed)	_____	
cancer	<input type="checkbox"/> Y	<input type="checkbox"/> N			
arthritis	<input type="checkbox"/> Y	<input type="checkbox"/> N			

C. ALLERGIES: *(Medications & Food) Please list*

D. CURRENT MEDICATIONS: *Please list*

E. Do you take aspirin or arthritis medication? Y N

Do you have an allergy to latex? Y N

Do you take blood thinner? Y N

4. FAMILY HISTORY: *(Indicate relative)*

F=father M=mother B=brother S=sister D=daughter
 S=son A=Aunt U=uncle GP=grandparent

Cancer of colon _____	Crohn's _____	High blood pressure _____	Tuberculosis _____
Cancer of stomach _____	Diabetes _____	Liver disease _____	Ulcerative colitis _____
Celiac disease _____	Gallstones _____	Mental Disorders _____	Ulcers _____
Colitis _____	Gastric cancer _____	Pancreatitis _____	Other _____
Colon Polyps _____	Heart attacks _____	Stroke _____	

5. SOCIAL HISTORY: *(If yes, please indicate how much per day.)*

Smoke Y N _____ (pack/day) Drink coffee Y N _____ Drink milk Y N _____
 Drink alcohol Y N _____ (oz./day) Drink tea Y N _____ Drink carbonated drinks Y N _____

6. REVIEW OF SYSTEMS: *(please indicate by checking appropriate boxes, use "other" to write in if necessary)*

HEENT	GYN	PSYCHOLOGICAL
History of nosebleeds <input type="checkbox"/> Y <input type="checkbox"/> N	Vaginal bleeding <input type="checkbox"/> Y <input type="checkbox"/> N	Inability to sleep <input type="checkbox"/> Y <input type="checkbox"/> N
Sinus-postnasal drip <input type="checkbox"/> Y <input type="checkbox"/> N	Vaginal discharge <input type="checkbox"/> Y <input type="checkbox"/> N	Panic attacks <input type="checkbox"/> Y <input type="checkbox"/> N
Ringling in ears <input type="checkbox"/> Y <input type="checkbox"/> N	Lower abdominal pain <input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety all the time <input type="checkbox"/> Y <input type="checkbox"/> N
Sore throat <input type="checkbox"/> Y <input type="checkbox"/> N	Irreg. vaginal bleeding <input type="checkbox"/> Y <input type="checkbox"/> N	Inability to think <input type="checkbox"/> Y <input type="checkbox"/> N
Other _____	Other _____	Other _____
PULMONARY	NEURO	DERMATOLOGIC
Chronic cough <input type="checkbox"/> Y <input type="checkbox"/> N	Dizziness <input type="checkbox"/> Y <input type="checkbox"/> N	Skin rash <input type="checkbox"/> Y <input type="checkbox"/> N
Cough up blood <input type="checkbox"/> Y <input type="checkbox"/> N	Vertigo <input type="checkbox"/> Y <input type="checkbox"/> N	Hair loss <input type="checkbox"/> Y <input type="checkbox"/> N
Asthma/Wheezing <input type="checkbox"/> Y <input type="checkbox"/> N	TIA <input type="checkbox"/> Y <input type="checkbox"/> N	Change in skin color <input type="checkbox"/> Y <input type="checkbox"/> N
Short of breath <input type="checkbox"/> Y <input type="checkbox"/> N	Memory Problems <input type="checkbox"/> Y <input type="checkbox"/> N	Itching <input type="checkbox"/> Y <input type="checkbox"/> N
Other _____	Other _____	Other _____
CARDIAC	OPHTHALMOLOGIC	DENTAL
Chest pain <input type="checkbox"/> Y <input type="checkbox"/> N	Red eye <input type="checkbox"/> Y <input type="checkbox"/> N	Gum bleed <input type="checkbox"/> Y <input type="checkbox"/> N
Swollen ankles <input type="checkbox"/> Y <input type="checkbox"/> N	Blurred vision <input type="checkbox"/> Y <input type="checkbox"/> N	Tooth pain <input type="checkbox"/> Y <input type="checkbox"/> N
Palpitations <input type="checkbox"/> Y <input type="checkbox"/> N	Painful eye <input type="checkbox"/> Y <input type="checkbox"/> N	Bad breath <input type="checkbox"/> Y <input type="checkbox"/> N
Short of breath lying <input type="checkbox"/> Y <input type="checkbox"/> N	Blind spots <input type="checkbox"/> Y <input type="checkbox"/> N	Sensitive teeth <input type="checkbox"/> Y <input type="checkbox"/> N
Other _____	Other _____	Other _____
GI	ENDOCRINE	MUSCULOSKELETAL
Nausea <input type="checkbox"/> Y <input type="checkbox"/> N	Hot/Cold <input type="checkbox"/> Y <input type="checkbox"/> N	Pain with movement that is better with rest <input type="checkbox"/> Y <input type="checkbox"/> N
Vomiting <input type="checkbox"/> Y <input type="checkbox"/> N	Excessive thirst <input type="checkbox"/> Y <input type="checkbox"/> N	Joint swelling <input type="checkbox"/> Y <input type="checkbox"/> N
Diarrhea <input type="checkbox"/> Y <input type="checkbox"/> N	Excessive urination <input type="checkbox"/> Y <input type="checkbox"/> N	Joint pain <input type="checkbox"/> Y <input type="checkbox"/> N
Constipation <input type="checkbox"/> Y <input type="checkbox"/> N	Significant weight loss <input type="checkbox"/> Y <input type="checkbox"/> N	Pain better with use of heating pad <input type="checkbox"/> Y <input type="checkbox"/> N
Difficulty swallowing <input type="checkbox"/> Y <input type="checkbox"/> N	Significant weight gain <input type="checkbox"/> Y <input type="checkbox"/> N	Other _____
Other _____	Other _____	
GU	HEMATOLOGIC	
Painful urination <input type="checkbox"/> Y <input type="checkbox"/> N	Tired <input type="checkbox"/> Y <input type="checkbox"/> N	
Blood in urine <input type="checkbox"/> Y <input type="checkbox"/> N	Irregular bleeding <input type="checkbox"/> Y <input type="checkbox"/> N	
Urethral discharge <input type="checkbox"/> Y <input type="checkbox"/> N	Easy bruising <input type="checkbox"/> Y <input type="checkbox"/> N	
Urinate frequently <input type="checkbox"/> Y <input type="checkbox"/> N	Blood clots <input type="checkbox"/> Y <input type="checkbox"/> N	
Difficulty initiating stream <input type="checkbox"/> Y <input type="checkbox"/> N	Other _____	
Other _____		

7. ADDITIONAL INFORMATION: _____

I have filled this form out to the best of my abilities and as accurately as possible.

PATIENT SIGNATURE _____

DATE _____

REVIEWING PHYSICIAN'S SIGNATURE _____

DATE _____