SWGA

Southwest Gastroenterology Associates

Today's Date_____

Name _____

DOB _____

PCP: _____ **Referring Provider:** _____

Chief Complaint **(main reason for your visit):** _____

_____

Preferred Pharmacy **including phone #:** _____

Preferred Lab:_____

History of Present Illness **(Please answer the following questions as much as possible):**

Where is the location of the problem/pain: _____

Duration (how long have you had this problem): _____ **days,** _____**weeks,** _____**months,** _____**years**

Severity (how severe is the problem): _____**mild** _____**moderate** _____**severe**

Is the problem: _____**worsening,** _____**improved,** _____**stable,** _____**gone now**

Is the problem: _____**constant or** _____**intermittent. Frequency of episodes**_____

What makes your condition worse? _____

What makes it better?_____

List medications/treatments that made it better_____

List medications/treatments that were not effective_____

List other associated symptoms _____

_____

Describe your Gastrointestinal problem in Details:_____

_____

_____

_____

List any treatments, tests or procedures you've had done for these symptoms

TESTS	**WHERE**	**WHEN**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

****If you are a new patient, the doctor-patient relationship is not considered to be established until the doctor has performed the first physical exam.**

Patient Signature _____ **Date:**_____

Family History	**CIRCLE**	**Relation**	**Age of onset**
__Cancer of Breast	MATERNAL/PATERNAL	_____	_____
__Cancer of Colon	MATERNAL/PATERNAL	_____	_____
__Cancer of Esophagus	MATERNAL/PATERNAL	_____	_____
__Cancer of Kidney	MATERNAL/PATERNAL	_____	_____
__Cancer of Liver	MATERNAL/PATERNAL	_____	_____
__Cancer of Ovaries	MATERNAL/PATERNAL	_____	_____
__Cancer of Pancreas	MATERNAL/PATERNAL	_____	_____
__Cancer of Stomach	MATERNAL/PATERNAL	_____	_____
__Cancer of Uterus	MATERNAL/PATERNAL	_____	_____
__Celiac Disease	MATERNAL/PATERNAL	_____	_____
__Crohn's Disease	MATERNAL/PATERNAL	_____	_____
__Diabetes Mellitus	MATERNAL/PATERNAL	_____	_____
__Disease of the liver	MATERNAL/PATERNAL	_____	_____
__Heart Disease	MATERNAL/PATERNAL	_____	_____
__Irritable Bowel Syndrome	MATERNAL/PATERNAL	_____	_____
__Polyps of colon	MATERNAL/PATERNAL	_____	_____
__Ulcerative Colitis	MATERNAL/PATERNAL	_____	_____
__Cancer Not listed above	MATERNAL/PATERNAL	_____	_____
__Other	MATERNAL/PATERNAL	_____	_____
__Other	MATERNAL/PATERNAL	_____	_____

Social History

Occupation_____

Education_____

Marital Status ____Married, ___Single, ___Divorced, ___Separated, ___Widowed, ___Domestic Partner

Smoking Status ____Never Smoker ____Former Smoker

____Current Every day smoker ____Current some day smoker

Smoking - How much? ____None, ____1 pk per week, ____2 pk per week, ____1/4 pk per day

____1/2 pk per day, ____1 pk per day, ____1&1/2 pk per day, ___2 pk per day, ___3+ pk per day

Has smoked since age _____

Tobacco - Years of use _____

Alcohol Intake ____None, ____Occasional, ____Moderate, ____Heavy

Alcohol - Years of use _____

How many days in the past year have you had a heaviy drinking consumption _____(4+ female, 5+ male)

Recreational drugs ____None, ____Yes, Type _____

Recreational Drugs - Years of use_____

Do you have an Advance Directive? ____Yes, ____No

Past Surgical History	DATE		DATE
__None	_____	__EUS (Endoscopic Ultrasound)	_____
__Adhesion	_____	__Flex Sigmoidoscopy	_____
__Anesthesia Problems	_____	__Hemorrhoidal Ligation	_____
__Appendectomy	_____	__Hemorrhoidectomy	_____
__Bariatric Surgery	_____	__Hernia Repair	_____
__Breast	_____	__Hysterectomy	_____
__C-Section	_____	__Interventional Pain Procedures	_____
__Cholecystectomy (Gallbladder)	_____	__Pacemaker	_____
__Colon Surgery	_____	__Pacemaker with Defibrillator	_____
__Colonoscopy	_____	__Prosthetic Heart Valve	_____
__Coronary Artery Bypass	_____	__Splenectomy	_____
__Coronary Stent	_____	__Tonsillectomy	_____
__EGD (Upper Endoscopy)	_____	__Transplant	_____
__ERCP	_____	__ Other_____	_____
		_____	_____

Past Medical History

__None
__Anemia
__Anticoagulation
__Anxiety Disorder
__Arthritis
__Asthma
__Atrial Fibrillation
__Autoimmune Disorder
__Bleeding Disorder
__BPH (enlarged prostate)
__Brain Tumor
__Cancer
__Celiac Disease
__CHF (Heart Failure)
__Cirrhosis
__Colon Cancer
__Colon Polyps
__COPD
__Coronary Artery Disease
__Crohn's Disease
__CVA/Stroke
__Depression
__Diabetes
__Diverticulitis (with inflammation)
__Diverticulosis
__DVT (Deep Vein Thrombosis)
__Endometriosis
__GERD/Acid Reflux
__GI Bleed
__Heart Attack (MI)
__Heart Disease
__Hepatitis A
__Hepatitis B
__Hepatitis C
__Hyperlipidemia
__Hypertension
__Hyperthyroidism
__Hypothyroidism
__Infertility
__Irritable Bowel Syndrome
__Kidney Disease
__Liver Disease
__Kidney Stones
__Neurologic Disorders
__Obesity
__Osteoporosis/Osteopenia
__PUD (Ulcer)
__Peripheral Vascular Disease
__Seizures/Epilepsy
__Sleep Apnea
__Tuberculosis
__Ulcerative Colitis
__Valvular Heart Disease
__ Other_____
_____

Review of Systems

Constitutional
__**Y**__**N** Fever
__**Y**__**N** Weight loss

Eye symptoms
__**Y**__**N** Double vision (diplopia)
__**Y**__**N** Eye pain (asthenopia)

ENT
__**Y**__**N** Ringing in ears
__**Y**__**N** Nose Bleeds
__**Y**__**N** Mouth sores

Gastroenterology
__**Y**__**N** Difficulty swallowing
__**Y**__**N** Pain on swallowing
__**Y**__**N** Nausea
__**Y**__**N** Heartburn
__**Y**__**N** Vomiting
__**Y**__**N** Vomiting blood
__**Y**__**N** Abdominal pain
__**Y**__**N** Jaundice
__**Y**__**N** Gas
__**Y**__**N** Bloating
__**Y**__**N** Diarrhea
__**Y**__**N** Constipation
__**Y**__**N** Change in bowel habits
__**Y**__**N** Bloody bowel movements
__**Y**__**N** Fecal incontinence
__**Y**__**N** Ascites (fluid in abdomen)

Cardiovascular
__**Y**__**N** Chest pain
__**Y**__**N** Palpitations

Pulmonary
__**Y**__**N** Coughing up blood
__**Y**__**N** Shortness of breath

Genitourinary
__**Y**__**N** Blood in urine
__**Y**__**N** Urinary incontinence

Integumentary
__**Y**__**N** Skin rash
__**Y**__**N** Itching

Neurological
__**Y**__**N** Headaches
__**Y**__**N** Seizures

Hematological
__**Y**__**N** Easy Bruising
__**Y**__**N** Easy Bleeding

Preventive Care Questions:

				DATE
Have you had a colonoscopy?	_____	YES	_____ NO	_____
Are you depressed?	_____	YES	_____ NO	_____
Have you had a PSA?	_____	YES	_____ NO	_____
Are you at risk of falls?	_____	YES	_____ NO	
When was you last Pap smear?				_____

Other information not included above:

_____

_____

_____

_____

Patient Signature_____**Date**_____

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