DATE _______________

Gastroenterology Specialties P.C. | Lincoln Endoscopy Center, L.L.C.

☐ NEW ☐ UPDATE

PATIENT HISTORY

SECTION 1 DEMOGRAPHICS

PATIENT'S LAST NAME | FIRST NAME | PREFERRED NAME | DATE OF BIRTH

MALE ☐ FEMALE ☐ ☐NURSING HOME RESIDENT? ☐ ASSISTED LIVING RESIDENT?

SECTION 2 SYMPTOMS

CHIEF COMPLAINT SUMMARY- PLEASE PROVIDE A BRIEF SUMMARY OF YOUR SYMPTOMS:

SECTION 3 PREVIOUS TESTING

PREVIOUS TESTS: PLEASE LIST ANY PROCEDURES, RADIOLOGY OR LAB YOU HAVE HAD FOR YOUR SYMPTOMS. INCLUDE FACILITY WHERE TESTS WERE PERFORMED AND APPROXIMATE DATE

SECTION 4 ANTICOAGULANT

LIST ANY ANTICOAGULANT/ANTIPLATELET MEDICATIONS (EXAMPLES: Coumadin, Plavix, Xarelto, Eliquis)

(Medication) (Dosage) (Reason for taking)

SECTION 5 PRESCRIPTION MEDICATIONS

LIST YOUR CURRENT PRESCRIPTION MEDICATIONS | PHARMACY & LOCATION

Medication / Dosage / How often | Medication / Dosage / How often

Medication / Dosage / How often | Medication / Dosage / How often

Medication / Dosage / How often | Medication / Dosage / How often

Medication / Dosage / How often | Medication / Dosage / How often

Medication / Dosage / How often | Medication / Dosage / How often

SECTION 6 OTC MEDICATIONS

LIST YOUR CURRENT OVER THE COUNTER MEDICATIONS (EXAMPLES: Vitamins, Supplements)

Medication / Dosage / How often | Medication / Dosage / How often

Medication / Dosage / How often | Medication / Dosage / How often

Medication / Dosage / How often | Medication / Dosage / How often

Medication / Dosage / How often | Medication / Dosage / How often

Medication / Dosage / How often | Medication / Dosage / How often

SECTION 7 ALLERGIES

MEDICATION ALLERGIES? YES ☐ NO ☐ LATEX ALLERGY? YES ☐ NO ☐ ASPARTAME ALLERGY YES ☐ NO

Medication allergic to | Rash ☐ Hives/Itching ☐ Shortness of breath ☐Other

Medication allergic to | Rash ☐ Hives/Itching ☐ Shortness of breath ☐Other

Medication allergic to | Rash ☐ Hives/Itching ☐ Shortness of breath ☐Other

Medication allergic to | Rash ☐ Hives/Itching ☐ Shortness of breath ☐Other

SECTION 8 SURGICAL HISTORY

PAST BLOOD TRANSFUSION? YES ☐ NO ☐ IF YES, Date of transfusion

COMPLICATIONS WITH SEDATION/ANESTHESIA? YES ☐ NO ☐ If YES, Describe

Surgery | Date | Surgery | Date

Surgery | Date | Surgery | Date

Surgery | Date | Surgery | Date

Surgery | Date | Surgery | Date

SECTION 9 SOCIAL HISTORY

MARITAL STATUS
- SINGLE ☐ SEPERATED ☐
- MARRIED ☐ WIDOWED ☐
- DIVORCED ☐ OTHER ☐

NUMBER OF CHILDREN ______

OCCUPATION ______

CAFFEINE USE LIST DAILY AMOUNT
- COFFEE ☐ ______
- TEA ☐ ______
- SODA ☐ ______
- ENERGY DRINKS ☐ ______
- NONE ☐

ALCOHOL USE
- NONE ☐
- SOCIAL USE ☐ AVG DRINKS PER WEEK ______
- DAILY USE ☐ AVG DRINKS PER DAY ______
- RECOVERING ALCOHOLIC ☐ DATE QUIT: ______

TOBACCO USE
- NEVER SMOKER ☐
- FORMER SMOKER ☐ YEAR QUIT ______
- CURRENT SMOKER ☐ CIGARETTES PER DAY ______

RECREATIONAL DRUG USE
- DOES NOT USE ☐
- PREVIOUS DRUG USE ☐ LIST DRUGS ______ YEAR QUIT ______
- CURRENT DRUG USE ☐ LIST DRUGS ______

SECTION 10 FAMILY HISTORY

LIST IMMEDIATE FAMILY HISTORY- Immediate family consists of **PARENTS, SIBLINGS and CHILDREN**

Condition	YES	NO	LIST RELATIONSHIP
CELIAC DISEASE	☐	☐	
COLON CANCER	☐	☐	
COLON POLYPS	☐	☐	
CROHN'S DISEASE	☐	☐	
LIVER DISEASE	☐	☐	
PANCREATIC DISEASE	☐	☐	
ULCERATIVE COLITIS	☐	☐	
ULCERS	☐	☐	

SECTION 11 REVIEW OF SYSTEMS

CONSTITUTIONAL
- CHILLS ☐
- FEVER ☐
- RECENT WEIGHT GAIN ☐ ______ LBS
- RECENT WEIGHT LOSS ☐ ______ LBS

ENMT
- DENTURES ☐
- HEARING LOSS ☐
- SINUS PROBLEMS ☐
- SORES IN MOUTH ☐

RESPIRATORY
- ASTHMA ☐
- COUGHING UP BLOOD ☐
- CHRONIC COUGH ☐
- EMPHYSEMA ☐
- HISTORY OF PULMONARY EMBOLISM ☐
- OXYGEN THERAPY ☐
- PNEUMONIA ☐
- SHORTNESS OF BREATH ☐

CARDIOVASCULAR
- CHEST PAIN ☐
- DEFIBRILLATOR ☐
- HEART ATTACK ☐
- HEART MURMUR ☐
- HYPERTENSION ☐
- IRREGULAR/RAPID HEARTBEAT ☐
- LOW BLOOD PRESSURE ☐
- PACEMAKER ☐
- STENTS IN THE LAST 30 DAYS ☐
- SWELLING OF LEGS, ANKLES, FEET ☐
- VALVE REPLACEMENT ☐
- VALVULAR DISEASE ☐

GASTROINTESTINAL
- ABDOMINAL PAIN ☐
- CHANGE IN APPETITE ☐
- CHANGE IN BOWEL HABITS ☐
- CONSTIPATION ☐
- DIARRHEA ☐
- DIVERTICULITIS ☐
- DIVERTICULOSIS ☐
- HEARTBURN ☐
- HEMORRHOIDS ☐
- HEPATITIS ☐
- INDIGESTION ☐
- INFLAMMATORY BOWEL DISEASE ☐
- JAUNDICE ☐
- NAUSEA ☐
- PANCREATITIS ☐
- COLON POLYP OR TUMOR ☐
- RECTAL BLEEDING ☐
- TROUBLE SWALLOWING ☐
- ULCER ☐
- VOMITING ☐

GENITOURINARY
- DIALYSIS ☐
- KIDNEY STONES ☐
- KIDNEY DISEASE ☐
- RENAL FAILURE ☐

MUSCULOSKELETAL
- ARTHRITIS ☐
- ARTIFICIAL JOINTS ☐

HEMATOLOGIC/LYMPHATIC
- ANEMIA ☐
- ANTICOAGULATION THERAPY ☐
- BLOOD CLOTS ☐
- BLOOD DISORDER ☐
- PHLEBITIS ☐
- TRANSFUSION ☐

ENDOCRINE
- CORTISONE THERAPY ☐
- DIABETES ☐
- THYROID PROBLEM ☐

IMMUNOLOGIC
- HEPATITIS A ☐
- HEPATITIS B ☐
- HEPATITIS C ☐
- TUBERCULOSIS ☐
- CDIFF ☐
- VRE ☐
- MRSA ☐

NEUROLOGICAL
- HEADACHES ☐
- PARALYSIS ☐
- STROKE ☐

PSYCHIATRIC
- ANXIETY ☐
- CONFUSION ☐
- DEPRESSION ☐
- MEMORY LOSS ☐
- PANIC ATTACKS ☐
- PHOBIAS ☐

INTEGUMENTARY
- HIVES ☐
- ITCHING ☐
- RASH ☐
- SORES ☐

CURRENT HEIGHT ______ FT ______ IN

CURRENT WEIGHT ______ LBS

PATIENT SIGNATURE: ______

DATE: ______