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

DATE _____ ☐ NEW ☐ UPDATE

PATIENT HISTORY

SECTION 1 DEMOGRAPHICS

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

☐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 _____

SECTION 8 SURGICAL HISTORY

PAST BLOOD TRANSFUSION? ☐ YES ☐ NO **DATE OF TRANSFUSION:** _____

COMPLICATIONS WITH SEDATION/ANESTH? ☐ YES ☐ NO **DESCRIBE:** _____

Surgery Date Surgery Date

Surgery Date Surgery Date

Surgery Date Surgery Date

Surgery Date

Please see other side

SECTION 9 SOCIAL HISTORY

MARITAL STATUS:

☐ SINGLE ☐ SEPERATED
☐ MARRIED ☐ WIDOWED
☐ DIVORCED ☐ OTHER

ALCOHOL USE:

☐ NONE
☐ SOCIAL USE AVG DRINKS PER WEEK: _____
☐ DAILY USE AVG DRINKS PER DAY: _____
☐ RECOVERING ALCOHOLIC DATE QUIT: _____

NUMBER OF CHILDREN: _____

OCCUPATION: _____

TOBACCO USE:

☐ NEVER SMOKER
☐ FORMER SMOKER YEAR QUIT: _____
☐ CURRENT SMOKER CIGARETTES PER DAY: _____

CAFFEINE USE: (LIST DAILY AMOUNT)

☐ NONE
COFFEE: _____
TEA: _____
SODA: _____
ENERGY DRINKS:

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**

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

LIST RELATIONSHIP

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:**