

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**GENDER**  Male  Female  Additional gender category: \_\_\_\_\_  Chooses not to disclose

**RACE**  
 White/Caucasian  Black/African American  Asian  
 American Indian/Alaska Native  Native Hawaiian or Other Pacific Islander  Patient declines to specify  
 Other  Unknown

**ETHNICITY**  
 Hispanic/Latino  Non-Hispanic or Latino  Patient declines to specify

**PREFERRED LANGUAGE**  
 English  Spanish  Other  Patient declines to specify

**CONTACT PREFERENCE**  
 Phone  Patient Portal  Text  Patient declines to specify

**FAMILY MEDICAL HISTORY**  No family history  No knowledge of family history

	<u>Mother</u>	<u>Father</u>	<u>Sister</u>	<u>Brother</u>	<u>Daughter</u>	<u>Son</u>
Colon Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Colon Polyps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Celiac Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liver Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Familial Multiple Polyposis Syndrome	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PCC-hereditary nonpolyposis colon cancer (Lynch)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IBD (Crohn's or Ulcerative colitis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Esophageal Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pancreatic Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**SOCIAL HISTORY**

**Occupation:** \_\_\_\_\_ **Marital Status:**  Single  Married  Divorced  Widowed

**Tobacco:**  Current smoker, how much: \_\_\_\_\_  Former smoker  Never smoker  Unknown if ever smoked

**Drug Use:**  None  I have used or experimented with street drugs

**Alcohol:**  None  Rarely  Daily  More than 2 days/week  Less than 2 days/week  I quit using alcohol

**Caffeine:**  None  Carbonated drinks  Coffee  Energy drinks  Tea

**DIAGNOSTIC STUDIES/TESTS** - Please document date beside test if relevant (i.e. EGD 2017, Colonoscopy 2000, etc.).

No history of previous gastro tests  Other: \_\_\_\_\_  
 Colonoscopy  EGD  ERCP  Flexible Sigmoidoscopy  
 Bravo pH capsule  Pill cam  Esophageal Manometry  Liver Biopsy

**ALLERGIES** -  No known allergies  No known drug allergies  
 Latex  Adhesive Tape  Eggs  Soy  Codeine sulfate  Demerol  
 Fentanyl  Midazolam  Propofol  Penicillins  Salicylates  Sulfa (Sulfanamide, Abx)

Other allergies: \_\_\_\_\_

Please list reactions: \_\_\_\_\_

**PREVIOUS PROCEDURES**

- AAA surgery or repair
- Carotid artery surgery
- Cholecystectomy
- Heart Valve Replacement
- Joint Surgery/Replacement
- Mastectomy
- PICC Line
- Small Bowel Resection
- No previous procedures
- Appendectomy
- C-Section
- Gastrectomy
- Hysterectomy
- Liver Transplant
- Medication Pump
- Port-A-Cath
- Tonsillectomy
- Other: \_\_\_\_\_
- Cardiac Defibrillator
- Colon Resection
- Gastric Bypass Surgery
- Ileostomy
- Lung surgery
- Nephrectomy
- Prostate Surgery
- Tubal Ligation
- Cardiac Stent placement
- CABG
- Hiatal Hernia Repair
- Inguinal Hernia Repair
- Lysis of adhesions
- Pacemaker Insertion
- Shunt/Graft/Fistula

- History of Procedure Complications**
- History of difficult airway/intubation
  - History of anesthesia complications
  - Problems with last procedure
  - History of Tracheostomy

If any anesthesia complications, explain: \_\_\_\_\_

**MEDICAL CONDITIONS** - Please document date beside event if relevant (i.e. Stroke 2017, Myocardial Infarction 2000, etc.)

- No medical conditions
- Achalasia
- Arthritis, Rheumatoid
- Bleeding disorder
- Bronchitis
- COPD, mild
- Crohn's
- Endometriosis
- Familial Adenomatous Polyps
- Gastritis
- Heart Valve Disease
- Hiatal Hernia
- Hypothyroidism
- Ischemic colitis
- Leukemia, chronic
- Lynch Syndrome
- Obesity
- Pulmonary HTN
- Seizure disorder
- Stomach Cancer
- Tuberculosis, History
- Other: \_\_\_\_\_
- ALS
- Atrial Fibrillation
- Blood transfusion
- Celiac Sprue
- CAD
- Depression
- Emphysema
- GERD
- Hemorrhoids
- High blood pressure
- IBD
- Ischemic Vascular Ds.
- Liver Cancer
- Melanoma
- Ovarian Cancer
- Rectal Cancer
- Skin Cancer
- Stroke
- Ulcer Disease, Peptic
- AAA - size? \_\_\_\_\_
- Asthma
- BPH
- Cervical Cancer
- Cirrhosis
- Diabetes
- Emphysema w/O<sup>2</sup>
- Fatty Liver, non-etho
- Glaucoma
- Hepatitis A
- High Cholesterol
- IBS
- Kidney Cancer
- Liver Disease
- Metal in Body
- Pancreatitis, acute
- Renal Failure
- Sleep apnea
- Thrombocytopenia
- Ulcerative Colitis
- Anemia
- Anxiety
- Breast Cancer
- Chronic fatigue
- Colon Cancer
- Diverticulosis
- Esophageal Cancer
- Fibromyalgia
- H-Pylori
- Hepatitis B
- HIV/AIDS
- Iron Deficiency anemia
- Kidney failure, chronic
- Lung Cancer
- Myocardial Infarction
- Pancreatic Cancer
- RSD (Reflex sympathetic dystrophy)
- Sleep Apnea w/CPAP
- TIA
- Arthritis, Degenerative
- Barrett's
- Brain Tumor
- CHF
- Colon Polyps
- Diveritculitis
- Esophagitis
- Gallstones
- Headaches
- Hepatitis C
- Hyperthyroidism
- Irregular Heart rate
- Kidney stones
- Lymphoma
- Multiple Sclerosis
- Prostate Cancer
- Strictures
- Thyroid disorder

**PHARMACY**

Name \_\_\_\_\_ Location \_\_\_\_\_ Phone \_\_\_\_\_

\*\*\*Do you consent to obtaining/importing a history of your medications purchased at pharmacies?\*\*\*

Yes  No

- IMMUNIZATIONS** - Please list date of injection
- None
  - PPD \_\_\_\_\_
  - Hep A, adult \_\_\_\_\_
  - Zoster \_\_\_\_\_
  - Hep B, adult \_\_\_\_\_
  - Influenza \_\_\_\_\_
  - Td (adult) \_\_\_\_\_
  - Pneumonia \_\_\_\_\_

**CURRENT MEDICATIONS** – Please include any and all BLOOD THINNING AGENTS!!!

I do not take any medications, including over the counter medications.

Drug Name	Strength	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**SIGNATURE:** \_\_\_\_\_ **TODAY'S DATE:** \_\_\_\_\_

Completed by:  Patient  Parent  Guardian