# PINEHURST MEDICAL CLINIC GASTROENTEROLOGY

**Name:** **Age:** **Date:**

**Reason for today's visit:**

**Please list any medical problems** (eg: High blood pressure, diabetes, arthritis, …)
1.
2.
3.
4.
5.

**Please list your prior surgeries (Date of surgery)**
1.
2.
3.
4.
5.

**Social**

Who do you live with?

Are you: ❑ married ❑ single ❑ divorced ❑ widowed?

Are you employed? ❑ Yes ❑ No (What is your job? )

Are you disabled? ❑ Yes ❑ No (If disabled, reason: )

**Family Medical History**

Is your father alive? ❑ Yes ❑ No (If no, age and cause of death )

Is your mother alive? ❑ Yes ❑ No (If no, age and cause of death )

How many sisters were/are in your family?

Have any sisters died? ❑ Yes ❑ No (If yes, age and cause )

How many brothers were/are in your family?

Have any brothers died? ❑ Yes ❑ No (If yes, age and cause )

List any medical problems that run in your family and who had them:

Has anyone in the family had colon cancer? ❑ Yes ❑ No (If yes, who and at what age? )

**List any medications you are ALLERGIC to:**

**Habits**

Do you currently smoke? ❑ Yes ❑ No (If yes, how many packs per day? )

Are you a former smoker? ❑ Yes ❑ No (If yes, when did you quit? )

Do you drink alcohol? ❑ Yes ❑ No (If yes, how many drinks per week? )

Do you chew tobacco? ❑ Yes ❑ No

How many cups of coffee per day? ❑ 0 ❑ 1-2 ❑ 3-4 ❑>4

How many cans of soda per day? ❑ 0 ❑ 1-2 ❑ 3-4 ❑>4

Please list the **MEDICATIONS** you take:

Do you take ❑ Goody's?, ❑ Advil (or Ibuprofin)?, ❑ Aspirin?,
❑ other similar medicine.

If yes, about how many pills per week?

Now please answer the questions on page 2. If there is anything else about your health you'd like us to be aware of, please mention it here.

**Please answer some questions about your general health**   **Date:**

| | | | | |
|---|---|---|---|---|
| Gen | Have you lost weight recently? ❑ Yes ❑ No (If yes, how many lbs? ) | | | Please explain those |
| | Have you gained weight? ❑ Yes ❑ No (If yes, how many lbs? ) | | | symptoms you currently |
| | ❑ Current ❑ Past ❑ None | | | have on a separate page |
| Eyes | Do you have trouble with your vision? (other than needing glasses) | ❑ Current | ❑Past | ❑None |
| | Do you have glaucoma? | ❑ Current | ❑Past | ❑None |
| ENT | Do you have hearing trouble | ❑ Current | ❑Past | ❑None |
| | Recurrent Nosebleeds? | ❑ Current | ❑Past | ❑None |
| | Sinus Problems? | ❑ Current | ❑Past | ❑None |
| | Hoarseness? | ❑ Current | ❑Past | ❑None |
| CV | Do you have chest pain or angina? | ❑ Current | ❑Past | ❑None |
| | Shortness of breath? | ❑ Current | ❑Past | ❑None |
| | Passing out spells? | ❑ Current | ❑Past | ❑None |
| | Swelling of ankles | ❑ Current | ❑Past | ❑None |
| Resp | Do you have a cough? | ❑ Current | ❑Past | ❑None |
| | Asthma or wheezing? | ❑ Current | ❑Past | ❑None |
| | Have you ever had tuberculosis? | ❑ Current | ❑Past | ❑None |
| GI: | Do you have heartburn? | ❑ Current | ❑Past | ❑None |
| | (If yes, ❑ daily ❑weekly ❑ less than once a week? | | | |
| | Do you have difficulty swallowing? | ❑ Current | ❑Past | ❑None |
| | Nausea? | ❑ Current | ❑Past | ❑None |
| | Vomiting? | ❑ Current | ❑Past | ❑None |
| | Diarrhea? | ❑ Current | ❑Past | ❑None |
| | Constipation? | ❑ Current | ❑Past | ❑None |
| | Uncontrolled leakage of stool? | ❑ Current | ❑Past | ❑None |
| | Rectal bleeding? | ❑ Current | ❑Past | ❑None |
| | Black stools that look like tar? | ❑ Current | ❑Past | ❑None |
| | Have you ever had hepatitis or jaundice? | ❑ Current | ❑Past | ❑None |
| GU | Do you currently have ❑ painful? Or ❑ frequent urination? | | | |
| | Blood in your urine? | ❑ Current | ❑Past | ❑None |
| | Have you had kidney stones? | ❑ Current | ❑Past | ❑None |
| | Any abnormal menstrual bleeding? (women) | ❑ Current | ❑Past | ❑None |
| MS | Do you have joint pain or arthritis? | ❑ Current | ❑Past | ❑None |
| | Back pain? | ❑ Current | ❑Past | ❑None |
| | Prominent muscle soreness or aches? | ❑ Current | ❑Past | ❑None |
| | If yes, where? | | | |
| Int | Do you have a skin rash | ❑ Current | ❑Past | ❑None |
| | Problems with repeated itching? | ❑ Current | ❑Past | ❑None |
| Neu | Frequent headaches? | ❑ Current | ❑Past | ❑None |
| | Have you had seizures? | ❑ Current | ❑Past | ❑None |
| | Have you ever had a stroke? | ❑ Current | ❑Past | ❑None |
| Heme | Have you ever had a blood transfusion? | ❑ Yes | ❑No | |
| | If yes, what year? | | | |
| | Do you have severe bleeding tendencies? | ❑ Yes | ❑No | |
| | If yes, explain? | | | |
| | Have you had blood clots in your ❑ Arms | ❑ Legs or | ❑Lungs | ❑None |
| Psych | Are you depressed? | ❑ Current | ❑Past | ❑None |
| | If yes/current, would you call this depression: ❑ mild | ❑ moderate | ❑ severe | |
| | Do you have problems with your nerves or feel under excessive stress? | ❑ Current | ❑Past | ❑None |
| | If yes/current, would you call this depression: ❑ mild | ❑ moderate | ❑ severe | |
| | Have you ever been a victim of sexual or physical abuse? | ❑ Current | ❑Past | ❑None |