

PINEHURST MEDICAL CLINIC GASTROENTEROLOGY

NAME: _____	AGE: _____	DATE: _____
--------------------	-------------------	--------------------

Reason for today's visit: _____

PLEASE CHECK BOX FOR ANY MEDICAL PROBLEMS

<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Breast Cancer
<input type="checkbox"/> Seizures	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Prostate Cancer
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Arthritis	
<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Depression/Anxiety	
<input type="checkbox"/> Asthma	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Anemia	

Other conditions _____

PLEASE CHECK BOX FOR PRIOR SURGERIES/PROCEDURES (please include endoscopy procedures)

<input type="checkbox"/> Tonsils	<input type="checkbox"/> Hip Replaced	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Hysterectomy (uterus removed)
<input type="checkbox"/> Heart Bypass	<input type="checkbox"/> Knee Replaced	<input type="checkbox"/> Colon Surgery	<input type="checkbox"/> Hernia
<input type="checkbox"/> Heart Valve	<input type="checkbox"/> C-section	<input type="checkbox"/> Colonoscopy	
<input type="checkbox"/> Back surgery	<input type="checkbox"/> Appendix	<input type="checkbox"/> Upper Endoscopy	

Other Surgeries _____

FAMILY MEDICAL HISTORY

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

Has anyone in your family had uterine, ovarian, and/or colon cancer? Yes No (If yes, which form of cancer, who & at what age)? _____

Has anyone had Crohn's disease, colitis, or pancreatic cancer? Yes No (If yes, who & at what age)? _____

SOCIAL

Who do you live with? _____

Are you? married single divorced widowed

Are you employed? Yes No If yes, What is your job? _____

Are you disabled: Yes No If disabled, Reason? _____

HABITS

Do you smoke? Yes No If yes, how many packs per day? _____

Did you smoke in the past? 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 YOUR CURRENT MEDICATIONS AND DOSAGES

ALLERGIES

Do you take Goody's or BC's Ibuprofen (Advil, Motrin, Nuprin, Aleve or similar medicines)

None

If yes, how many pills per week? _____

If there is anything else about your health you would like us to be aware of, please mention it here.

PREVENTATIVE CARE

Have you ever had a colonoscopy for colorectal cancer screening?

Please answer some questions about your general health

Date: _____

Gen	Do you have a weight problem? Have you lost weight recently? Have you gained weight? Any fever or sweating chills?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, how many lbs? _____ <input type="checkbox"/> no <input type="checkbox"/> Yes, how many lbs? _____ <input type="checkbox"/> no <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> none	Please explain below the symptoms you have currently:
Eyes	Do you have trouble with your vision? (other than needing glasses) Do you have glaucoma?	<input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None	
ENT	Do you have hearing trouble? Recurrent nosebleeds? Sinus problems? Hoarseness?	<input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None	
CV	Do you have chest pain or angina? Shortness of breath? Passing out spells? Swelling of your ankles?	<input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None	
Resp	Do you have a cough? Asthma or wheezing? Have you ever had tuberculosis?	<input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None	
GI	Do you have heartburn? If yes, <input type="checkbox"/> daily, <input type="checkbox"/> weekly, <input type="checkbox"/> less than once a week Do you have difficulty swallowing? Nausea? Vomiting? Diarrhea? Constipation? Uncontrolled leakage of stool? Rectal Bleeding? Black stools that look like tar? Have you ever had hepatitis or jaundice?	<input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None	
GU	Do you currently have <input type="checkbox"/> painful? or <input type="checkbox"/> frequent urination? Blood in your urine? Have you had kidney stones? Abnormal menstrual bleeding? (women only)	<input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None	
MS	Do you have Joint pain or arthritis? Back pain? Prominent muscle soreness or aches? ...If yes, where? _____ _____	<input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None	
INT	Do you have a skin rash? Problems with repeated itching?	<input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None	
NEU	Frequent headaches? Have you had seizures? Have you ever had a stroke?	<input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None	
HEME	Have you ever had a blood transfusion? Do you have severe bleeding tendencies? If yes, please explain: _____ _____	<input type="checkbox"/> yes, year _____ <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no	
	Have you had treatment for a blood clots?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
PSYCH	Are you depressed? If yes, would you call this depression: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe? Do you have problems with your nerves or feel under excessive stress? If yes, would you call this stress/nerves: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe? Have you ever been a victim of sexual or physical abuse?	<input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None <input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> None	