Pinehurst Medical Clinic
GASTROENTEROLOGY

Name: Age: Date:

Reason for today's visit:

Please check box for any medical problems:

- ☐ Stroke
- ☐ Seizure
- ☐ Thyroid
- ☐ COPD/Emphysema
- ☐ Asthma
- ☐ Heart Trouble
- ☐ Heart Attack
- ☐ Irregular Heart Beat
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Depression/Anxiety
- ☐ Anemia
- ☐ Breast Cancer
- ☐ Prostate Cancer

Other Conditions

Please check box for prior surgeries/procedures (please include endoscopy procedures):

- ☐ Tonsils
- ☐ Heart Bypass
- ☐ Heart Valve
- ☐ Back Surgery
- ☐ Hip Repleaced
- ☐ Knee Replaced
- ☐ C-section
- ☐ Appendix
- ☐ Gallbladder
- ☐ Colon Surgery
- ☐ Colonoscopy
- ☐ Upper Endoscopy
- ☐ Hysterectomy (utuerus removed)
- ☐ Hernia

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 in your family had Chron'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 medicine) ☐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 the questions on page 2 (over)

Please answer some questions about your general health. Date: _______________

	Question	Response			Please explain below symptoms you have currently:
Gen	Do you have any weight problems?	☐Yes	☐No		
	Have you lost weight recently?	☐Yes, how many lbs?______	☐ No		
	Have you gained weight?	☐Yes, how many lbs?______	☐ No		
	Any fever or sweating chills?	☐Current	☐Past	☐None	
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	
	Hoarsness?	☐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 your ankles?	☐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	
	Vomitting?	☐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	☐Current	☐Past	☐None	
	Blood in your urine?	☐Current	☐Past	☐None	
	Have you had kidney stones?	☐Current	☐Past	☐None	
	Abnormal menstrual bleeding? (women only)				
MS	Do you have				
	Joint pain or arthritits?	☐Current	☐Past	☐None	
	Back pain?	☐Current	☐Past	☐None	
	Prominent muscle sorness or aches?	☐Current	☐Past	☐None	
	If yes, where?				
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?	☐Current	☐Past	☐None	
	Do you have severe bleeding tendencies?	☐Current	☐Past	☐None	
	If yes, please explain:				
PSYCH	Are you depressed?	☐Current	☐Past	☐None	
	If yes, 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, would you call this stress/nerves: ☐Mild ☐Moderate ☐Severe				
	Have you ever been a victim of sexual or physical abuse?	☐Current	☐Past	☐None	