PINEHURST MEDICAL CLINIC GASTROENTEROLOGY

NAME: AGE: DATE:

Reason for today's visit:

PLEASE CHECK BOX FOR ANY MEDICAL PROBLEMS

☐Stroke	☐Heart trouble	☐Diabetes	☐Breast Cancer
☐Seizures	☐Heart attack	☐Kidney disease	☐Prostate Cancer
☐Thyroid	☐Irregular heart beat	☐Arthritis	
☐COPD/Emphysema	☐High blood pressure	☐Depression/Anxiety	
☐Asthma	☐High cholesterol	☐Anemia	

Other conditions _____

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

☐Tonsils	☐Hip Replaced	☐Gallbladder	☐Hysterectomy (uterus removed)
☐Heart Bypass	☐Knee Replaced	☐Colon Surgery	☐Hernia
☐Heart Valve	☐C-section	☐Colonoscopy	
☐Back surgery	☐Appendix	☐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 QUESTIONS ON PAGE 2 (over)

Please answer some questions about your general health Date: _____

Gen	Do you have a weight problem?	☐Yes ☐No			Please explain below the symptoms you have currently:
	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	
	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 your 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	
	Abnormal menstrual bleeding? (women only)	☐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, year _____		☐no	
	Do you have severe bleeding tendencies?	☐yes		☐no	
	If yes, please explain: _____				
	_____				
	_____				
	Have you had treatment for a blood clots?	☐Yes ☐No			
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	