Gastroenterology Associates of Cleveland, Inc.

New Patient Gastrointestinal / Medical History Form

Please fill out this form completely and bring it with you on your first visit. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*	❑ M ❑ F	Date of Birth:
Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Partnered		
Previous or Referring Doctor:		Date of Last Physical Exam:

PERSONAL HEALTH HISTORY

Adult Immunizations and Dates:	❑ Tetanus Booster	❑ Influenza
	❑ Hepatitis A	❑ Hepatitis B

HEALTH HABITS AND PERSONAL SAFETY

Caffeine:	☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day? _____
Chocolate:	☐ None ☐ 2 - 3x Daily ☐ 2 – 3 x Week
Alcohol:	Do you drink alcohol? ..... ☐ Yes ☐ No If yes, what kind? ☐ wine, ☐ beer, ☐ whiskey How many drinks per week? _____
Tobacco:	Do you use tobacco? ..... ☐ Yes ☐ No ☐ Cigarettes - Packs/day_____ ☐ Chew - #/day _____ ☐ Pipe - #/day _____ ☐ Cigars - #/day _____ ☐ # of Years _____ ☐ or Year Quit _____

GASTROINTESTINAL HISTORY

☐	Poor Appetite	☐	Rectal Bleeding	☐	Wheezing or Asthma
☐	Nausea/Vomiting	☐	Black Bowel Movements	☐	Milk or Lactose Intolerance/Wheat Allergy
☐	Vomiting Blood	☐	Abdominal Discomfort/Pain	☐	Colon Polyps in the Past
☐	Frequent Heartburn	☐	Belching	☐	Colon Cancer in the Past
☐	Heartburn Awakens	☐	Bloating	☐	Liver Disease or Jaundice
☐	Trouble Swallowing	☐	Diarrhea	☐	Hepatitis A
☐	History of ulcers	☐	Constipation	☐	Hepatitis B or C
☐	Hiatal Hernia	☐	Bowel Habit is Unpredictable	☐	Gallstones
☐	Chronic Cough	☐	Lost Bowel Control or Soiling	☐	Unexplained Weight Loss
☐	Persistent Hoarseness	☐	Passing a lot of gas/flatus	☐	Frequent/Recent Travel out of the Country
☐	Food sticks with swallowing	☐	Frequent Sore Throat	☐	Diverticulitis or Diverticulosis

GENERAL REVIEW OF SYSTEMS

General		Throat/Teeth and Gums		**Kidneys/Urinary System**	
☐	Weight Loss or Gain	☐	Sore tongue	☐	Frequency of urination
☐	Fatigue	☐	Dry mouth	☐	Urgent need to urinate
☐	Fever or Shaking Chills	☐	Dentures	☐	Difficulty starting urination
☐	Night Sweats	☐	Non-healing sores	☐	Burning or pain on urination
☐	Trouble Sleeping	☐	Bleeding gums	☐	Blood in urine
☐	Weakness	**Neck**		☐	Change in Urinary Stream
Skin		☐	Lumps	☐	Dribbling after urination
☐	Rashes/Change in moles	☐	Swollen glands	☐	Constant loss of urine
☐	Itching	☐	Pain	☐	With cough/sneeze do you lose urine
☐	Dryness	☐	Stiffness		
☐	Color changes	**Respiratory/Lungs**		**Vascular**	
Ears		☐	Cough either dry or wet	☐	Calf pain when walking

☐	Decreased hearing	☐	Sputum	☐	Leg cramping/swelling
☐	Ringing in the ears	☐	Coughing up blood	**Musculoskeletal**	
Eyes		☐	Cough either dry or wet	☐	Muscle or joint pain
☐	Redness	☐	Wheezing	☐	Stiffness of joints
☐	Blurry or double vision	☐	Painful breathing	☐	Back pain
☐	Flashing lights	**Cardiovascular**		☐	Traumatic injury
☐	Cataracts	☐	Chest pain or discomfort	**Hematologic**	
☐	Pain	☐	Heart Murmur	☐	Easy bruising
Nose		☐	Mitral Valve Prolapse	☐	Bleeding for prolonged periods of time
☐	Stuffiness	☐	Swelling of legs or ankles	☐	Were you ever told that you are anemic
☐	Nasal discharge	☐	High Blood Pressure	**(Notes)**	
☐	Nose bleeds	☐	High Cholesterol		
☐	Sinus pain/problems	☐	Shortness of breath with activity		
☐	Drainage in back of throat	☐	Heart Attack in the Past		
		☐	Irregular Heart Beat		
Neurologic		**Endocrine**			
☐	Dizziness	☐	Heat or cold intolerance		
☐	Fainting	☐	Sweating		
☐	Seizures	☐	Frequent urination		
☐	Weakness in arms or legs	☐	Constant thirst		
☐	Numbness or Tingling	☐	Change in appetite		
☐	Shaking or Tremor	☐	Thin hair		

ALLERGY HISTORY

☐		☐	Iodine or Shellfish	☐	Hay Fever

Please list other allergies or drug reactions:

MEDICATION HISTORY

(Please list all medications, either prescription or over the counter, vitamins, herbal preparations, nutritional products)

	Medication	Dose	Number of times taken each day
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

MEDICAL PROBLEMS / HOSPITALIZATIONS / SURGERIES

Please check off or list all medical conditions for which you are currently being treated. (ex. high blood pressure)

☐	Hip or Knee Replacement	1	
☐	Heart Valve Replacement	2	
☐	Internal Cardiac Defibrillator (ICD)	3	
☐	Heart Pacemaker	4	
☐	Electronic Urinary Devices	5	
☐	Neurologic (Nerve) Stimulators	6	
☐	Port-a-Cath	7	
☐	PICC Line	8	
If you have the information card for the device, please bring it with you		9	
		10	

FAMILY HISTORY

	Age	Medical Problems	Deceased
Father			☐
Mother			☐
Brother/Sister			☐
Brother/Sister			☐
Brother/Sister			☐
Brother/Sister			☐
Child			☐
Child			☐
Child			☐

MENTAL HEALTH

Is stress a major problem for you? ..... ☐ Yes ☐ No
Do you feel depressed? ..... ☐ Yes ☐ No
Do you panic when stressed? ..... ☐ Yes ☐ No
Do you have problems with eating or your appetite? ..... ☐ Yes ☐ No
Do you cry frequently? ..... ☐ Yes ☐ No
Do you have trouble sleeping? ..... ☐ Yes ☐ No

PLEASE EXPLAIN IN YOUR OWN WORDS WHY YOU ARE HERE TODAY.

Patient Signature _____ Today's Date_____

ADDITIONAL NOTES	
Body System	

Reviewed at time of interview/examination by:

Physician/PA/NP _____ Date: _____