**Dr. Kahlam, M.D. Gastroenterology**

## PATIENT INFORMATION

**DATE:** _____ **REFERRING DOCTOR**: _____

**NAME**: _____ **AGE:** _____ **HEIGHT**: _____ **WEIGHT**: _____

**PLEASE CHECK IF YOU HAVE ONE OF THE FOLLOWING**

| | | | |
|---|---|---|---|
| – Nausea | – abdominal pain | – Incontinence of stool | – Jaundice |
| – Vomiting | – abdominal cramps | _ rectal pain | |
| – Heartburn | – weight loss | _ Rectal pressure | |
| – indigestion | – Blood in stool | – Distension | |
| – Swallowing difficulty | – Rectal bleeding | – Gas | |
| – regurgitation | – Diarrhea | – Flatulence | |
| – chest pain | – Constipation | – mucus | |

Do you have any other symptoms or problems other than specified above? _____

List any tests you have have had done_____

**PAST GI HISTORY:** **Have you had any of the following problems?**

| | | | |
|---|---|---|---|
| __ Gerd | __ colitis | __ Colon polyps | __ Ascites |
| __ Barrett's esophagus | __ ulcerative colitis | __ Irritable bowel syndrome | __ Pancreatitis |
| __ Hiatal hernia | __ Crohn's disease | __ Liver problems | |
| __ ulcers | __ Diverticulitis | __ hepatitis | |
| __ Varices | __ Diverticulosis | __ Cirrhosis | |
| __ Schatsky's ring | __ Colon cancer | __ Jaundice | |

**PAST MEDICAL HISTORY:** **Have you had any of the following problems?**

| | | |
|---|---|---|
| – Diabetes Type 1 or 2 | __ seizure disorder | __Kidney Disease |
| – High blood pressure | __ Stroke | __ Kidney Stone |
| – Atrial fibrillation | __ TIA | __ Arthritis |
| – Arrhythmia | __ Emphysema/ COPD | __ Rheumatoid Arthitis |
| – Heart Murmur | __ Asthma | __ Anemia |
| – Angina | __ Hypothyroidism (Low) | __ Clots in Legs/ DVT |
| – Congestive heart failure | __ Hyperthyroidism (High) | __ Osteoporosis |
| – Heart Attack/ MI | __ Depression | __ Rheumatic fever |
| – Migraine | __ High Cholesterol | __ Tuberculosis |
| – Multiple sclerosis | __ Glaucoma | __ Lyme's disease |
| – Alcoholism | __ Psoriasis | __ Parkinson's disease |
| – Fibromyalgia | __ Anxiety | |

OTHER if not on the list _____

**SURGERY:** **Have you ever had any operations? If so list and when**

1 _____ 2 _____ 3 _____ 4 _____

5 _____ 6 _____ 7_____ 8 _____

**MEDICATIONS:** **Please list medications you take regularly including those you buy over the counter:**

1 _____ 2 _____ 3 _____ 4 _____

5 _____ 6 _____ 7 _____ 8 _____

**ALLERGIES:** **Are you allergic to any medications** **YES** ____ **NO** _____

1_____ 2 _____ 3 _____ 4 _____

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**FAMILY HISTORY:**

Do any of your blood relatives have any of the following? If yes who?

Colon cancer ____ Polyps___ other cancer ____

List any of the following has or had any medical problems?

| | Blood pressure | Diabetes | Stroke | Heart Disease | Cancer | Type of cancer |
|---|---|---|---|---|---|---|
| Father | _____ | _____ | _____ | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ | _____ | _____ | _____ |
| Brother | _____ | _____ | _____ | _____ | _____ | _____ |
| Sisters | _____ | _____ | _____ | _____ | _____ | _____ |
| Grandparents | _____ | _____ | _____ | _____ | _____ | _____ |
| Aunt/ Uncle | _____ | _____ | _____ | _____ | _____ | _____ |

**SOCIAL HISTORY:**

**TOBACCO:** Smoke: Yes __ No __ If yes, Packs per day ____

If no did you ever smoke? Yes ___ No ___ how many years ____

**ALCOHOL**: Do you drink alcohol? Yes___ No____ If so how much ___

**ILLICIT DRUGS:** Did you ever use illegal drugs _____

**OCCUPATION:** What kind of work do you do _____

**MARITAL STATUS:** Single ___ Married ____ Divorced _____ Widowed _____ Separated _____

**COFFEE:** Cups daily ____ Other caffeine _____

**REVIEW OF SYSTEMS:** **Please CIRCLE if you have any of the following symptoms**

**CONSTITUTIONAL:** appetite change weight loss fever chills malaise fatigue weakness

**HEENT:** vision changes nose bleeds sneezing sore throat Ear pain facial pain

**NECK:** Neck pain swelling stiffness lumps

**SKIN:** itching Rash hives skin cancer easy bruising lesions

**CHEST**: cough sputum chest pain coughed up blood wheezing

**HEART:** Palpitations angina shortness of breath ankle swelling

**GU:** blood in urine pain with urination increased frequency incontinence

**CNS:** Headaches numbness or weakness in arms or legs speech disturbance visual disturbance

**PSYCH HX:** depression anxiety

**JOINTS/ BONES:** pains swelling deformity back pain muscle pains