

GASTROENTEROLOGY GROUP OF ROCHESTER, LLP

Name: _____ DOB: _____ Age: _____ Today's date: _____

Referring MD: _____ PCP: _____ OB/GYN: _____ Height _____ Weight _____

Reason for visit: (Circle all that apply, or note reason in 'other') Screening colonoscopy History of polyps Rectal bleeding
Diarrhea Weight loss Nausea Vomiting Abdominal pain Constipation Heartburn/reflux Barrett's esophagus
Difficulty swallowing Crohn's disease Ulcerative colitis Other: _____

Medications: (Include prescriptions, over-the-counter medications, vitamins/supplements, minerals, herbs) ** Note - If additional space is needed, attach separate sheet Separate sheet attached

Medication name	Dosage	How often taken

Use of anti-inflammatory products/Blood thinners: aspirin/Ecotrin _____ (mg) daily/wkly./as needed
 ibuprofen/Advil/Motrin _____ (mg) daily/wkly./as needed naproxen/Aleve _____ (mg) daily/wkly./as needed
 Coumadin/Plavix _____ (mg) daily/wkly. Other: _____

Allergies/Reactions: Sedatives/Anesthetics- Name/Type of reaction: _____
 Latex- Type of reaction: _____ Adhesives/Tape/Bandaids
 Medications- Name/Type of reaction: _____

Personal Medical History: (Circle all that apply; note 'past' or 'present')

	Past	Present
Neurological illness/Stroke/Seizure	_____	_____
Eye/Ear/Nose/Throat/Thyroid disease	_____	_____
Anxiety/Depression/ Psychiatric disorder	_____	_____
Cancer * Type: _____	_____	_____
(* Please complete reverse side of form)		
Chronic cough/Shortness of breath	_____	_____
Lung disease (asthma/COPD)	_____	_____
Sleep apnea/CPAP use	_____	_____
GERD/Barrett's esophagus	_____	_____
Heartburn/Reflux/Nausea/Vomiting	_____	_____
Difficult/Painful swallowing	_____	_____
High blood pressure/Heart valve disease	_____	_____
Angina/Heart attack/Cardiac stent	_____	_____
Irregular heartbeat/Pacemaker/Defibrillator	_____	_____
Anemia/Easy bruising or bleeding	_____	_____
Jaundice/Liver disease/Gallbladder disease	_____	_____
Bladder/Kidney stones or disease	_____	_____
Unexplained Wt. loss or gain/Eating disorders	_____	_____
Abdominal pain/Diarrhea/Constipation/IBS	_____	_____
Crohn's disease/Ulcerative colitis	_____	_____
Black/Bloody stools	_____	_____
Polyps (Stomach or Colon)	_____	_____
Arthritis/Fibromyalgia/Gout	_____	_____
Diabetes/Hypoglycemia	_____	_____
Skin disease	_____	_____
Have you ever had a blood transfusion?	Yes- year(s) _____	No
Do you require antibiotics prior to dental work?	Yes	No

Other Chronic Medical Problems:

Surgical History: (List type of surgery and surgery dates) _____

Social History:

Alcohol/Drug use (How much/When quit): _____
_____ N/A
Tatoos/Piercings (Location(s), list year placed): _____

Smoking (How much and when quit): N/A

Occupation: _____
Marital Status: _____

Dietary Habits:

(List how often you use any of the following, circle daily or weekly)
Milk amount _____ daily/weekly
Soda pop amount _____ daily/weekly
Coffee/Tea amount _____ daily/weekly
Gum chewing frequency _____ daily/weekly

Form Reviewed by: _____ Date: _____

Pt. Signature: _____