ADVANCED GASTRO CONSULTANTS

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Date:_____Name:_____Age:_____Date of Birth:_____Sex: M or F

Do you have a Living Will?_____Are you here for a SCREENING COLONOSCOPY: YES or NO

Date of last Colonoscopy:_____Endoscopy:_____

Please check if you are CURRENTLY having of the following symptoms: ☐ Abdominal Pain ☐ Bloating / Belching / Gas ☐ Hiccups ☐ Difficulty swallowing ☐ Heartburn / Reflux ☐ Nausea ☐ Vomiting ☐ Constipation ☐ Blood in vomit ☐ Blood in stool ☐ Anemia ☐ Other:_____

PATIENT MEDICAL HISTORY check all that apply:

☐ Cirrhosis
☐ Colon Cancer
☐ Colon Polyps
☐ Crohn's Disease
☐ Diverticulitis
☐ Diverticulosis
☐ End Stage Renal Disease (ESRD)
☐ GERD
☐ Hemorrhoids
☐ Hepatitis B
☐ Hepatitis C (HCV)
☐ Hiatal Hernia
☐ IBS
☐ Liver Disease
☐ Ulcerative Colitis
☐ Stomach/Intestinal Ulcers
☐ Anemia
☐ Anxiety/Depression
☐ Arthritis
☐ Asthma
☐ Cataracts
☐ Diabetes
☐ Glaucoma
☐ HIV/AIDS
☐ High Cholesterol
☐ Hypertension
☐ Hypothyroidism
☐ Migraines
☐ Obesity
☐ Osteoporosis
☐ Pancreatitis
☐ Seizures
☐ Sleep apnea/CPAP
☐ Stroke
☐ Chronic Kidney Disease (CKD)
☐ Congestive Heart Failure (CHF)
☐ COPD/Emphysema
☐ Coronary Artery Disease
☐ Myocardial Infarction/heart attack
☐ Nerve/Muscle Disease
☐ Cancer: Type _____
☐ Other:_____

Current medications: Please list dose and directions: (INCLUDE supplements, vitamins, OTC medications, etc.)

_____
_____
_____
_____

Are you currently taking any of the following blood thinners? ☐ Coumadin ☐ Plavix ☐ Xarelto ☐ Eliquis ☐Other: _____

Are you currently taking any of the following NSAIDS? ☐ Advil ☐ Aleve ☐ BC Powder ☐ Goody's Powder ☐ Ibuprofen ☐ Naprosyn ☐ Other: _____

Allergies and Reactions:_____

Social History:

Blood Transfusion (s): If yes when/why_____

Tobacco use: ☐ Never ☐ Every Day ☐ Some Days ☐ Former: How long: How many years:___Packs per day: _____

Alcohol: How often:_____ How much:_____ Type:_____

Caffeine: How often:_____ How much:_____ Type:_____

Exposure to blood/bodily fluids: If yes, please explain:_____Tattoos: YES or NO

Surgeries: Please check all that apply and include the dates:

☐ Colon sx_____
☐ Colonoscopy_____
☐ Upper Endoscopy (EGD____
☐ Hemorrhoid sx___
☐ Gallbladder sx___
☐ Gastric sx_____
☐ Breast sx_____
☐ C-section_____
☐ Heller myotomy__
☐ Nissen_____
☐ Brain Surgery____
☐ Appendectomy__
☐ CABG/Heart sx__
☐ Defibrillator_____
☐ Pacemaker_____
☐ Fracture_____
☐ Small Intestine sx_____
☐ Laparotomy_____
☐ Obesity
☐ Spinal sx_____
☐ Thyroidectomy___
☐ Tonsillectomy_____
☐ Valve Replacement_____
☐ Vasectomy_____
☐ Tubal ligation _____
☐ Hysterectomy ___
☐ Abd/Vag_____
☐ Joint replacement_____
☐ Liver sx_____
☐ Hemia sx_____
☐ Prostate sx_____
☐ Transplant sx_____
☐ Other_____

Hospitalizations (reason and year):_____

Other Physicians involved in your healthcare:

Cardiology:_____Previous Gastroenterology:_____

Neurology:_____Other please list name and specialty:_____

Nephrology:_____

Hematology / Oncology:_____

Endocrinology:_____

Family hx

_____
_____

Children hx

_____
_____

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