Associated Gastroenterologists of Central New York, P.C.

PATIENT HISTORY FORM		
Last Name:	First Name:	MI:
Date of Birth (mm-dd-yyyy)	Date of Visit (mm-dd-yyyy)	
Primary Care Provider's Name:	Referring Provider's Name:	

ARE YOU COMING IN FOR A COLONOSCOPY SCREENING? YES ( ) NO ( )
IF NO THEN WHAT IS/ARE THE COMPLAINT(S)_____

_____

Location: Where is the pain/problem?	
Quality: Example: normal versus abnormal texture/color	
Severity: How severe on a scale of 1 to 5, 5 being worst	
Duration: How long have you had this pain/problem?	
Timing: Does the pain/problem occur at a specific time?	
Context: Where were you at the onset of this problem?	
Associated signs/symptoms: What other problems have you been having?	
Modifying factors: What makes the pain/problem worse or better?	

Allergies (List all medication you are allergic to):

_____

Medications (List all current medications):

Medication **Dose**

_____

_____

_____

_____

PAST GI AND MEDICAL HISTORY (check all that apply):					
	Y	N		Y	N
History of stomach ulcer/s			Anemia		
History of duodenal ulcer/s			History of GI Bleeding		
History of Colon cancer			Bleeding disorder		
Any other cancer ?			Diverticulosis		
History of colon polyps			Diverticulitis		
Hepatitis A			Liver Problems		
Hepatitis B			Cirrhosis of the liver		
Hepatitis C			Gallstones		
Acute Pancreatitis			Gastric bypass		
Chronic pancreatitis			Other weight loss surgery		
Ulcerative colitis			Hemorrhoids		
Crohn's disease			Heart disease		
Any other GI disease?			Hives or Eczema		
Diabetes			Comments		
Blood transfusions					

PAST SURGICAL HISTORY (if any):		
Date	Surgery/Procedure	Hospital

FAMILY HISTORY (check all that apply):							
	Colon Cancer	Colon Polyps	Liver Disease	Ulcerative Colitis	Crohn's Disease	Celiac disease	Pancreatits
Mother							
Father							
Brother							
Sister							
Grandfather							
Grandmother							
Aunt							
Uncle							

PAST HOSPITALIZATIONS/ILLNESSES (if any):		
Date	**Reason**	**Hospital, City, State**

PATIENT SOCIAL HISTORY

MARITAL STATUS:

SINGLE MARRIED SEPARATED DIVORCED WIDOWED

NATURE OF EMPLOYMENT: _____
Sedentary, heavy-duty, etc.?

Alcohol Use:

Previous: _____ Never: _____ Rarely: _____ Regularly/Quantity: _____

Tobacco Use:

Never smoked: _____ Ex-smoker: _____ Current smoker: _____ Packs/day: _____

REVIEW OF SYSTEMS

Constitutional					
Good health	Yes	No	Weight loss	Yes	No
Fever	Yes	No	Bleed Too Long	Yes	No
Anemia	Yes	No	Chronic Fatigue	Yes	No
Eyes					
Blurred Vision	Yes	No	Glaucoma	Yes	No
Cardiovascular					
Chest Pain	Yes	No	Shortness of Breath	Yes	No
Palpitations	Yes	No	Swelling of Feet	Yes	No
Respiratory					
Wheezing	Yes	No	Spitting up Blood	Yes	No
Asthma	Yes	No	Frequent Cough	Yes	No
Gastrointestinal					
Nausea	Yes	No	Loss of Appetite	Yes	No
Vomiting	Yes	No	Frequent Diarrhea	Yes	No
Constipation	Yes	No	Fluid in Abdomen	Yes	No
Heartburn	Yes	No	Difficulty Swallowing	Yes	No
Early Satiety	Yes	No	Blood in Stool	Yes	No
Painful BM's	Yes	No	Fecal Incontinence	Yes	No
Integumentary					
Rash	Yes	No	Change in Hair	Yes	No
Itching	Yes	No	Change in Nails	Yes	No

Ear/Nose/Mouth/Throat					
Nosebleeds	Yes	No	Chronic Sinus Issue	Yes	No
Mouth Sores	Yes	No	Swollen Neck Glands	Yes	No
Bad Breath	Yes	No	Bleeding Gums	Yes	No
Genitourinary					
Blood in Urine	Yes	No	Frequent Urination	Yes	No
Painful Periods	Yes	No	Burning/painful Urination	Yes	No
Musculoskeletal					
Joint Pain	Yes	No	Weakness of Muscles	Yes	No
Muscle Pain	Yes	No	Muscle Cramps	Yes	No
Neurological					
Seizures	Yes	No	Frequent Headaches	Yes	No
Psychiatric					
Depression	Yes	No	Memory Loss/Dementia	Yes	No
Anxiety	Yes	No	Confusion	Yes	No
Endocrine					
Diabetes	Yes	No	Thyroid Disorder	Yes	No
Hematological/Lymphatic					
HIV / AIDS	Yes	No	Bleed or Bruise Easily	Yes	No
Blood Clots:	Yes	No	Swollen Glands	Yes	No
Allergy/Immunology					
Food Allergy	Yes	No	Environmental Allergy	Yes	No
Skin Reaction	Yes	No	Allergy to Intravenous Dye	Yes	No
For Women Only					
Is there a chance you could be pregnant?				Yes	No
What is the date of your last period?				_____	

AUTHORIZATION & SIGNATURE

I have answered the above questions correctly (to the best of my knowledge). It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

_____
Patient/Parent/Guardian Signature

_____
Date

_____
Reviewer (Physician/NP)

_____
Date