

**GASTROENTEROLOGY ASSOCIATES**

4367 NW AMERICAN LANE  
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(386) 758-6094  
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NAME \_\_\_\_\_ DATE \_\_\_\_\_

REASON FOR VISIT \_\_\_\_\_

DRUG ALLERGIES (PLEASE LIST REACTIONS) \_\_\_\_\_

**PLEASE LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING. IF YOU BROUGHT A MEDICATION LIST WITH YOU, PLEASE TURN THAT IN UPON COMPLETION OF YOUR PAPERWORK. ALSO, BE SURE TO INCLUDE OVER THE COUNTER MEDICATIONS AS WELL AS ANY NUTRITIONAL SUPPLEMENTS.**

NAME & STRENGTH

FREQUENCY

<u>NAME &amp; STRENGTH</u>	<u>FREQUENCY</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

*-IF YOU NEED MORE SPACE, PLEASE SEE THE RECEPTIONIST AT THE FRONT DESK-*

**PROCEDURE/SURGICAL HISTORY**

(PLEASE FILL IN AND CIRCLE THE APPROPRIATE ANSWERS)

**UPPER ENDOSCOPY:**

DATE: \_\_\_\_\_ DOCTOR: \_\_\_\_\_ FACILITY: \_\_\_\_\_

**COLONOSCOPY:**

DATE: \_\_\_\_\_ DOCTOR: \_\_\_\_\_ FACILITY: \_\_\_\_\_

POLYPS REMOVED?    YES    NO

**COLON RESECTION:**    LEFT    RIGHT    **REASON FOR RESECTION:**    COLON CANCER    DIVERTICULITIS

**HEART STENTS:**    HOW MANY: \_\_\_\_\_

DATE: \_\_\_\_\_ DOCTOR: \_\_\_\_\_ FACILITY: \_\_\_\_\_

**HYSTERECTOMY:**    PARTIAL    COMPLETE

GALLBLADDER	CATARACT	APPENDIX	GASTRIC BYPASS	HEMORRHOID
INGUINAL HERNIA	VENTRAL HERNIA	UMBILICAL HERNIA	LIVER TRANSPLANT	KIDNEY TRANSPLANT
KNEE REPLACEMENT	HIP REPLACEMENT	TONSILS	ADENOIDS	ILEOSTOMY

**PERSONAL HEALTH HISTORY**

(PLEASE FILL IN AND CIRCLE THE APPROPRIATE ANSWERS)

Does anyone in your family have a history of colon cancer?    YES    NO

If yes, whom? \_\_\_\_\_  
(Please include the relationship)

Do you smoke cigarettes?    YES    NO    If yes, how many per day? \_\_\_\_\_ Per week? \_\_\_\_\_

Do you drink alcoholic beverages?    YES    NO    If yes, what type? \_\_\_\_\_

How often? \_\_\_\_\_ How many drinks? \_\_\_\_\_

Do you use illicit drugs?    YES    NO    If yes, what type? \_\_\_\_\_

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**CURRENT HEALTH CONDITIONS**

(PLEASE CIRCLE **ONLY** THE SYMPTOMS THAT YOU ARE CURRENTLY EXPERIENCING)

**GENERAL:**    APPETITE LOSS    FATIGUE    FEVER    WEIGHT LOSS    ANOREXIA

**SKIN:**    SKIN LESIONS    PRURITUS (ITCHY SKIN)    RASH

**HEENT:**    VISION LOSS    DIZZINESS    NOSE BLEED    SORE THROAT    VOICE CHANGES

**RESPIRATORY:**    DIFFICULTY BREATHING    CHRONIC COUGH    COUGHING UP BLOOD    WHEEZING

**CARDIO:**    CHEST PAIN    DIFFICULTY BREATHING LYING DOWN    SWELLING OF ARMS/LEGS  
FAINING    BLACKING OUT    PALPATATIONS    SHORTNESS OF BREATH

**GASTRO:**    ABDOMINAL PAIN    BLOATING    BLOODY STOOL    CHANGE IN BOWEL HABITS  
INCONTINENCE OF STOOL    NAUSEA    VOMITING    VOMITING BLOOD  
HEARTBURN    PAINFUL OR DIFFICULTY SWALLOWING    JAUNDICE

**FEMALE:**    BLOOD IN URINE    PAINFUL URINATION    FLANK PAIN    NIPPLE DISCHARGE

**MUSCULOSKELETAL:**    MUSCLE PAIN    SWELLING OF EXTREMITIES

**NEUROLOGICAL:**    SEIZURES    VISUAL CHANGES    MUSCLE TWITCHING

**PSYCHIATRIC:**    ANXIETY    DEPRESSION    MOOD CHANGES    THOUGHTS OF SUICIDE

**ENDOCRINE:**    APPETITE CHANGES    COLD INTOLERANCE    HEAT INTOLERANCE

**HEMATOLOGY:**    ABNORMAL BLEEDING    EASY BRUISING    EASY BLEEDING  
PROLONGED BLEEDING    SPONTANEOUS BLEEDING

**SIGN X** \_\_\_\_\_ **DATE** \_\_\_\_\_