Patient Information

First Name:		Last Name:	
Date of Birth:		Social Security#:	
Driver's License:		E-Mail:	
Home Phone:		Cell Phone:	
Address, City, State, Zip:			
Emergency Contact Name, Relationship: Phone Number:			
Referral Source:	Physician l Friend/Relative l Online l Hospital l Other: _____		
Referring Physician: Address: Phone Number:			
Primary Care Physician: Address: Phone Number:			
GABH Physician:	Pedram Enayati, MD l Omid Shaye, MD		

PATIENT MEDICAL HISTORY

Date: _____Referring MD: _____Primary MD: _____

Patient Name: Mr./Mrs./Dr./Miss. _____ Sex: M F Date of Birth _____
First Name Last Name

HISTORY & PHYSICAL. Reason for Visit:

_____

_____

MEDICAL HISTORY—Check ALL past or present illnesses

GASTROINTESTINAL
- ☐ IBS (Irritable Bowel Syndrome)
- ☐ GERD/Heartburn
- ☐ Barrett's Esophagus
- ☐ Gastritis
- ☐ H. pylori infection
- ☐ Peptic Ulcer Disease
- ☐ Colonic polyp
- ☐ Hemorrhoids
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ Gallstones
- ☐ IBD-Crohn's
- ☐ IBD- Ulcerative Colitis
- ☐ Pancreatitis
- ☐ Gallstones
- ☐ Chronic constipation
- ☐ GI Bleeding

LIVER
- ☐ Elevated liver tests
- ☐ Fatty Liver
- ☐ Cirrhosis
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Jaundice

CANCER
- ☐ Colon Cancer
- ☐ Esophageal Cancer
- ☐ Stomach Cancer
- ☐ Breast Cancer
- ☐ Pancreatic Cancer
- ☐ Endometrial Cancer
- ☐ Liver Cancer
- ☐ Leukemia
- ☐ Lymphoma

BLOOD
- ☐ Anemia
- ☐ Iron deficiency
- ☐ Bleeding abnormalities
- ☐ Blood clots

HEART
- ☐ High Blood Pressure (Hypertension)
- ☐ Heart Attack (Myocardial Infarction)
- ☐ Congestive Heart Failure
- ☐ Cardiomyopathy
- ☐ Premature Heart Disease in Family
- ☐ Arrhythmia
- ☐ Atrial fibrillation
- ☐ Elevated Triglycerides
- ☐ Elevated Cholesterol
- ☐ Rheumatoid Fever
- ☐ Heart Valve Disease
- ☐ Endocarditis

RESPIRATORY
- ☐ COPD (Emphysema)
- ☐ Asthma
- ☐ Tuberculosis (TB)
- ☐ Sleep Apnea

ENDOCRINOLOGY
- ☐ Diabetes, Type I (Insulin dependent)
- ☐ Diabetes, Type II (Pill dependent)
- ☐ Hypothyroid
- ☐ Hyperthyroid

MUSCULOSKELETAL
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Raynaud's
- ☐ Lupus
- ☐ Scleroderma
- ☐ Gout

RENAL
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Dialysis

GYNENECOLOGIC
- ☐ Menstrual irregularity
- ☐ Infertility
- ☐ Polycystic Ovarian Syndrome
- ☐ Stress Urinary Incontinence

PSYCHOLOGICAL
- ☐ Bipolar Disorder
- ☐ Anxiety
- ☐ Depression
- ☐ OCD—Obsessive Compulsive Disorder
- ☐ Schizophrenia

NEUROLOGICAL
- ☐ Stroke
- ☐ Insomnia
- ☐ Seizures
- ☐ Migraines
- ☐ Headache
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____

SURGICAL HISTORY: Check ALL that apply

GASTROINTESTINAL
- ☐ Appendix
- ☐ Liver Transplant
- ☐ Hiatal Hernia Repair
- ☐ Inguinal Hernia Repair
- ☐ Gallbladder Removal
- ☐ Gastric Bypass
- ☐ Gastric Banding
- ☐ Sleeve Gastrectomy
- ☐ Exploratory Surgery for Intestinal Adhesions
- ☐ Colon Resection, partial
- ☐ Gastric Resection, complete
- ☐ Ventral Hernia Repair
- ☐ Colonoscopy
- ☐ Upper Endoscopy (EGD)
- ☐ ERCP

MUSCULOSKELETAL
- ☐ Hip replacement
- ☐ Spine surgery
- ☐ Knee replacement

CARDIAC
- ☐ Heart Stent Placement
- ☐ CABG (Coronary Artery Bypass Grafting)
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Heart Transplant
- ☐ LVAD Device
- ☐ Abdominal Aneurysm Repair
- ☐ Heart Valve Replacement

GYNECOLOGICAL
- ☐ Vaginal Hysterectomy
- ☐ Abdominal Hysterectomy
- ☐ Ovary Removal (Oophorectomy)
- ☐ C-Section
- ☐ Breast Biopsy
- ☐ Mastectomy (Right, Left or Both)

GENITORURINARY
- ☐ TURP (Transurethral Resection of the Prostate)
- ☐ Cystectomy (Bladder Removal)
- ☐ Kidney Transplant
- ☐ Nephrectomy (Kidney Removal)
- ☐ Prostatectomy (Prostate Removal)
- ☐ Radiation for prostate cancer

OTHER
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Glaucoma surgery
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____

ISSUES WITH ANESTHESIA
Yes___ No ____ If yes, please explain_____

MEDICATIONS List ALL prescription, supplements, and over the counter medications

Medication	Dose	Medication	Dose
1. _____	_____	6. _____	_____
2. _____	_____	7. _____	_____
3. _____	_____	8. _____	_____
4. _____	_____	9. _____	_____
5. _____	_____	10. _____	_____

ALLERGIES
No Known Drug Allergies___ Iodine___ Sulfa___ Aspirin___ Penicillin___ Other _____

FAMILY HISTORY—Check ALL diseases that have occurred in your family and indicate family member affected

- ☐ Crohn's Disease
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Peptic Ulcer Disease
- ☐ Celiac Disease
- ☐ Liver Disease
- ☐ Cirrhosis of Liver
- ☐ Hemochromatosis
- ☐ Gallstones
- ☐ Pancreatitis
- ☐ Colon Polyps
- ☐ 10+ Colon Polyps
- ☐ Stomach Cancer
- ☐ Esophageal Cancer
- ☐ Pancreatic Cancer
- ☐ Colorectal Cancer
- ☐ Breast Cancer
- ☐ Uterine Cancer
- ☐ Cervical Cancer
- ☐ Vaginal Cancer
- ☐ Anemia
- ☐ Heart Disease
- ☐ Obesity
- ☐ Diabetes
- ☐ Hypertension
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

SOCIAL HISTORY

Smoking: Do you *currently* smoke? Yes ____ No ____ If yes, how many packs per day?_____
Smoked in the past? Yes ____ No ____ If yes, how many packs per day?_____

Alcohol: Do you drink alcohol? Yes ____ No ____ If yes, how many times in a week? _____

Drugs: Do you use illicit drugs? Yes ____ No ____ If yes, how often? _____
Type: Cocaine__ Ecstasy__ Heroin__ Marijuana__ Pain Medications__ Other_____

GI REVIEW OF SYMPTOMS Are you currently experiencing any of the following symptoms?

☐ **Abdominal Pain**, if yes, for how long? _____

☐ Intermittent (on and off)	☐ Sharp	☐ Worsened with Food	☐ Relieved by bowel movement	☐ Neither
☐ Constant	☐ Cramping	☐ No effect with Food	☐ Relieved by passing gas	
☐ Dull Ache	☐ Other_____			
☐ Burning	☐ Better with Food			

☐ **Bloating** If yes, for how long?_____
- ☐ Eructation (burping)
- ☐ Flatulence (gas)

☐ **Heartburn,** If yes, for how long? _____
- ☐ Often
- ☐ Not Often
- ☐ Awaken you at night
- ☐ Relieved with the following medications: _____ _____

❑ **Diarrhea,** if yes, for how long?_____
- ☐ Number of bowel movements per day:____
- ☐ Blood present
- ☐ Mucus Present

☐ **Rectal Bleeding,** if yes, for how long? _____
- ☐ Bright red blood
- ☐ Blood mixed in stool
- ☐ Blood on toilet paper

☐ **Constipation**, if yes, for how long?_____
- ☐ Number of bowel movements per week?___
- ☐ Remove stool with finger sometimes
- ☐ Require laxatives or enemas frequently
- ☐ Sense of incomplete emptying

❑ **Food stuck in esophagus,** if yes, for how long? _____
- ☐ Liquids
- ☐ Solids
- ☐ Both

❑ **Painful swallow,** if yes, for how long? _____
- ☐ Liquids
- ☐ Solids
- ☐ Both

☐ **Vomiting,** if yes, for how long? _____
- ☐ Flatulence (gas)
- ☐ Bile (green)

☐ **Recent changes in bowel habits,** yes ____ No ____ If yes, for how long? _____
- ☐ Alternating diarrhea and constipation
- ☐ Cramp-like pain in the abdomen
- ☐ Pain before, during or after bowel movement
- ☐ Thin stools
- ☐ Black stools
- ☐ Full quickly
- ☐ Jaundice
- ☐ Nervous bowel
- ☐ Poor appetite

☐ **Any weight changes in the last 6 months?** Yes ____ No ____
If yes, loss____ or gain _____ How many pounds? _____

GENERALIZED REVIEW OF SYMPTOMS Check ALL that apply

CONSTITUTIONAL
- ☐ Decreased appetite
- ☐ Excessive fatigue
- ☐ Night Sweats
- ☐ Weight Loss

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Irregular heartbeat
- ☐ Leg swelling
- ☐ Poor exercise tolerance
- ☐ Sleep on stack of pillows

ENDOCRINE
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Menopause
- ☐ Weight gain(10+ lbs)

PSYCHIATRIC
- ☐ Depression
- ☐ Suicidal Intention
- ☐ Trouble Sleeping

NEUROLOGICAL
- ☐ Dizziness
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Seizures

MUSCULOSKELETAL
- ☐ None
- ☐ Back pain
- ☐ Recent injury
- ☐ Swelling

HEMATOLOGICAL
- ☐ None
- ☐ Anemia
- ☐ Bleeding and/or bruising
- ☐ Past transfusion (s)

URINARY
- ☐ Burning with urination
- ☐ Frequency of urination
- ☐ Loss of bladder control

EYES, EARS, NOSE,THROAT
- ☐ Dentures/Partials
- ☐ Ear pain/Ringing
- ☐ Eye pain/Blurred vision
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Inability to smell
- ☐ Neck Lumps

SKIN
- ☐ Bruising
- ☐ Itching
- ☐ Jaundice
- ☐ Rash
- ☐ Skin cancer
- ☐ Tattoo

RESPIRATORY
- ☐ Chronic cough
- ☐ Oxygen use
- ☐ Sleep Apnea
- ☐ Shortness of breath
- ☐ Wheezing/Asthma