Eisenman & Eisenman M.D.
ADVANCED GASTRO CONSULTANTS

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.)

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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 □ Naproxen □ 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____________
□ Hernia 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___________________
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Children HX_________________
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