East Carolina Gastroenterology, PA
Medical and Personal History **Date of this visit:___________________**

Last name:________________________First:______________ MI:_______

Address:___________________________________City:_________________Zip:________

Date of Birth:___________Age: _____Sex: M F Marital Status S M D W # of Children___

How did you find us: ☐ Friend/Family ☐ Phone Book ☐ Referred by doctor

Primary Care Physician:__________________ Referring Physician______________________

Social Security #:_________________________ Occupation:_____________________________

Home phone:_______________ Work Phone:___________________ Cell Phone_________________
Please circle which telephone # you prefer to receive appointment reminder phone calls.

Spouse/Sponsor's Info- Name:___________________________ DOB:_________SS#______________

Emergency Contact Name/tel#____

Preferred Pharmacy______________________________ Email_______________________________
Please provide us with a personal (not work related) e-mail address and you will be able to access your personal health records, request appointments, request medication refills, receive educational material, view your statements, send to and receive messages from our clinical staff. These benefits are available through our secure patient portal which you can access from your smart phone or computer.

Chief Reason For visit:______________
Do not write here____
____
____
____

Past Medical/Surgical History: (check all that apply)
☐ Hepatitis A/B/C ☐Stomach(gastric) ulcers ☐ Colon Cancer ☐Crohns disease ☐Ulcerative colitis
☐ Colon Polyps ☐Pancreas disease ☐Diabetes ☐Blood in stool ☐ High blood pressure
☐ Chronic Bronchitis(COPD) ☐Asthma ☐Heart Attack ☐Heart disease ☐Anemia ☐Irritable bowel syndrome ☐ Acid Reflux ☐ High Cholesterol ☐ Sleep Apnea ☐ Seizures/Epilepsy ☐ Stroke
☐ Others medical history:____
Past Surgeries:____
____
____

Previous tests:(when and where)
☐ Upper endoscopy: ☐ Colonoscopy: ☐ CT scan: ☐ Barium Enema
☐ Upper GI Xray: ☐ Gallbladder Ultrasound: ☐ Barium swallow

Social History:
Alcohol: ☐ Yes ☐ No **Tobacco use**: ☐ Current ☐ Former ☐ Never
Daily use of NSAIDS like aspirin, Aleve, Motrin, Ibuprofen, Goody Powder etc: ☐ Yes ☐ No
Recreational Drug use: ☐ Yes ☐ No **Any tattoos**?_____ **Any blood transfusions?** ☐ Yes ☐ No
Allergies to MEDICATIONS, foods or LATEX (List name and type of reaction):
____
____

Medication names	Dosage	Frequency		Medication names	Dosage	Frequency

Do you take Coumadin/Warfarin, Pradaxa, Xarelto, Eliquis or other blood thinners? ☐ Yes ☐ No
Other Current Medications and Doses(include over the counter and herbal medications):
____

Family History (Check all that apply)

	Colon cancer	**Colon Polyps**	**Stomach cancer**	**Uterine cancer**	**Genital/urinary Cancer**	**Ulcerative colitis**	**Crohn's disease**	**Liver disease**
Father								
Mother								
Siblings								
Child								
Grandparents								

Do you have any of these problems? **(Please check all that apply)**

General
- ❑ Weight loss
- ❑ Loss of appetite
- ❑ Fatigue

ENT/Respiratory
- ❑ Hearing loss
- ❑ Nose bleeds
- ❑ Ear pain
- ❑ Frequent sore throat
- ❑ Hoarseness
- ❑ Chronic cough

Cardiology
- ❑ Shortness of breath
- ❑ Dizziness
- ❑ Chest pain
- ❑ Palpitation
- ❑ Swollen ankles

Genitourinary
- ❑ Difficulty urinating
- ❑ Painful urination
- ❑ Blood in urine
- ❑ Decreased force in urinating
- ❑ Incontinence of urine
- ❑ History of kidney stones
- ❑ Heavy periods

Neurology
- ❑ Frequent headaches
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Dizziness
- ❑ Failing vision
- ❑ Seizures

Psychiatry
- ❑ Nervousness/anxiety
- ❑ Depression
- ❑ Moodiness
- ❑ Memory loss
- ❑ Sleeping difficulty

Musculoskeletal
- ❑ Recurrent low back pain
- ❑ Arthritis
- ❑ Numbness/tingling in hands or feet

Gastrointestinal
- ❑ Blood in stool
- ❑ Constipation
- ❑ Diarrhea
- ❑ Difficulty swallowing
- ❑ Change in bowel habit
- ❑ Painful defecation
- ❑ Heartburn
- ❑ Nausea or vomiting
- ❑ Abdominal pain

Patient Signature:____________________________.
Date:_________________________.