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 ☐ Bronchitis(COPD)
☐Asthma ☐Heart Attack ☐Heart disease ☐Anemia ☐Irritable bowel syndrome ☐ Acid Reflux
☐ High Cholesterol ☐ Sleep Apnea ☐ Seizures/Epilepsy ☐ Stroke ☐Depression
☐ 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

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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								

Review of Systems ***(Please check the box if you currently have any of these symptoms)***

General	Weight loss	Loss of appetite	Fatigue
Gastrointestinal	Blood in stool Difficulty swallowing Heartburn	Constipation Change in bowel habit Nausea or vomiting	Diarrhea Painful defecation Abdominal pain
Cardiology	Shortness of breath Palpitation	Dizziness Swollen ankles	Chest pain
ENT/Respiratory	Hearing loss Frequent sore throat	Nose bleeds Hoarseness	Ear pain Chronic cough
Genitourinary	Difficulty urinating Decreased force in urinating Heavy periods	Painful urination Incontinence of urine	Blood in urine History of kidney stones
Neurology	Frequent headaches Dizziness	Glaucoma Failing vision	Cataracts Seizures
Psychiatry	Nervousness/anxiety Memory loss	Depression Sleeping difficulty	Moodiness
Musculoskeletal	Recurrent low back pain	Arthritis	Numbness/tingling in hands or feet

Patient Signature: ____ **Date:** _____________________