EASTERN PENNSYLVANIA GASTROENTEROLOGY AND LIVER SPECIALISTS, P.C.

Please complete this form prior to your visit to our office.

Today's Date: _________________________

Patient Name: _______________________________ Maiden Name (if applicable) ______________________

Mailing Address: ____

Email Address: ____

Cell Phone: __________________________ Home Phone: ______________________________________

Social Security Number: _________________________ Date of Birth: ___/___/______ Sex: M __ F__

Race: ___Asian ___Native Hawaiian___ Other Pacific Islander___ Black/African American ___
___White ___ Greater than 1 Race ___ Unreported/Refused to Report

Ethnicity: ___ Hispanic/Latino ___ Not Hispanic/Latino ___Unreported/Refused to Report

Preferred Language: ____

Referred by: ______________________________ Family Doctor: __________________________

Reason for Appointment: ____

MEDICATIONS – List all prescription and non-prescription medications you presently take including: aspirin, vitamins, herbs, dietary supplements, calcium, laxatives, eye drops, etc. (attach additional pages if necessary)

Pharmacy Preference _______________________________ Phone: _________________________

Mail Order Pharmacy _______________________________ Phone: _________________________

Medicines	Dose	How often	Occasional	Reason for Use

Medical History

Arthritis/Gout ……………………….	No	Yes
Atrial Fibrillation……………………	No	Yes
Asthma/COPD……………………….	No	Yes
Bleeding Tendency	No	Yes
Breathing Problems	No	Yes
Cancer	No	Yes
Diabetes	No	Yes
Fibromyalgia……………………..…	No	Yes
GERD ……………………….…	No	Yes
Heart Failure/Heart Attack	No	Yes
History of Colon Polyps………… …	No	Yes
History of Diverticulitis………… …	No	Yes
History of Blood Clots………… ..…	No	Yes
Hypertension	No	Yes
High Cholesterol……………………	No	Yes
Kidney Stones………………………	No	Yes
Migraines…………………….....…	No	Yes

Other: ____

Previous Hospitalizations: ___________________________

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Medical History Continued:

Kidney Disease ………………... ...…….	No	Yes
Sleep Apnea…………………………	No	Yes
Seizures	No	Yes
Stress/Anxiety	No	Yes
Stroke	No	Yes
Ulcerative Colitis/Crohn's………..	No	Yes
Vitamin D Deficiency ………………	No	Yes

Additional Medical Problems: ________________________
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Allergies – List all allergies to drugs, medicines, bee sting, etc. and give reaction.
Are you allergic to latex? __yes ___ no
Are you allergic to Penicillin? ___ yes ___ no

Drug/Agent	Reaction	Drug/Agent	Reaction

FAMILY HISTORY – Please provide the following information on your parents, siblings and children:

GI Malignancy	Yes ___	No ___	If yes, who ________________	At What Age ___________
Colon Polyps	Yes ___	No ___	If yes, who________________	At What Age ___________
Liver Disease	Yes ___	No ___	If yes, who ________________	At What Age ___________
Crohns Disease	Yes ___	No ___	If yes, who _______________	At What Age ___________
Ulcerative Colitis	Yes ___	No ___	If yes who ________________	At What Age ___________
Colon Cancer	Yes ___	No ___	If yes, who _______________	At What Age ___________

Social History

Alcohol Use:	Never ☐ Occasionally ☐ Moderate ☐ Daily☐
Tobacco Use:	Never ☐ Previously, but quit ☐ Current packs/day_________
Caffeine Use:	Never ☐ Rarely☐ Moderate☐ Daily☐
Drug Use:	Never ☐ Rarely ☐ Moderate☐ Daily Drugs used: _________________

PREVIOUS GI EVALUATIONS – Give the year, location (hospital or other) and, if known, result of the following medical studies:

Study:	Year	Location	Result (circle NL if normal- ? if unknown)
Colonoscopy			NL ? Polyps: yes no
Upper Endoscopy (EGD)			NL ?
Abdominal CAT (CT Scan)			NL ?
Abdominal Ultrasound			NL ?
Barium Enema			NL ?
Upper GI Series			NL ?

OPERATIONS: List all surgical operations, (especially abdominal, hernia, hemorrhoids, hysterectomy, cardiac, heart valve, pacemaker, artificial joints, cataracts, etc.) Give the year, physician and location

Operation	Year	Physician	Hospital-City-State