Account # _____ Appointment Date: _____ Appointment Time: _____ Arrive at: _____

Please bring your insurance card and a photo ID

CENTRAL TEXAS GASTROENTEROLOGY CONSULTANTS

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Age: _____

Briefly Describe Your Current Symptoms:

_____

_____

_____

_____

_____

YES	NO	
❍	❍	Have you seen your primary doctor or another provider for this problem?
❍	❍	Has any testing (labs, x-rays, imaging, etc.) been done?

If yes, where? _____

Current Medications

❍ None ❍ See List (If you have a list, we would be happy to make a copy.)

Medicine	Dose	How often taken?	Reason for taking?

Allergies

❍ Patient has no known allergies ❍ Patient has no known drug allergies

General
❍ Dairy Products ❍ Latex ❍ Peanuts ❍ Shellfish
❍ Other: _____

Medications
❍ Penicillins ❍ Sulfa Drugs ❍ Codeine ❍ Iodine
❍ Demerol ❍ Fentanyl ❍ Versed ❍ Aspirin
❍ Other _____

_____

Review of Systems

❍ None

Constitutional	Yes	No
Recent travel outside of the U.S.	❍	❍
Recent fever greater than 101	❍	❍
Recent/Unintentional weight gain greater than 10 lbs	❍	❍
Recent/Unintentional weight loss greater than 10 lbs	❍	❍

EENMT	Yes	No
Recent change in eyesight	❍	❍
Nose bleeds	❍	❍
Difficulty swallowing	❍	❍
Choking	❍	❍
Hoarse voice	❍	❍
Post-nasal drainage	❍	❍
Sore throat	❍	❍

Heart/Lung	Yes	No
Chest pain	❍	❍
Fainting	❍	❍
Shortness of breath with exercise	❍	❍
Swelling of legs and feet	❍	❍
Wheezing	❍	❍
Chronic Cough	❍	❍
Coughing up blood	❍	❍

Gastrointestinal	Yes	No
Abdominal pain	❍	❍
Abdominal swelling	❍	❍
Change in bowel habits	❍	❍
Constipation	❍	❍
Diarrhea	❍	❍
Gas	❍	❍
Heartburn	❍	❍
Jaundice	❍	❍
Nausea	❍	❍
Rectal bleeding	❍	❍
Stomach cramps	❍	❍
Vomiting	❍	❍
Black tarry stools	❍	❍
Small or narrow stools	❍	❍
Mucus in stools	❍	❍

Urinary	Yes	No
Frequent urinary infections	❍	❍
Difficulty urinating	❍	❍
Blood in urine	❍	❍

Musculoskeletal	Yes	No
Back Pain	❍	❍
Joint Pain	❍	❍
Joint Swelling	❍	❍
Muscle Pain	❍	❍

Neurological	Yes	No
Frequent headaches	❍	❍
Migraine	❍	❍
Seizures	❍	❍
Tremors	❍	❍

Psychiatric	Yes	No
Panic attacks	❍	❍
Anxiety	❍	❍
Depression	❍	❍

Allergic/Immunologic	Yes	No
HIV exposure	❍	❍
Anaphylactic reaction	❍	❍

Hematologic/Lymphatic	Yes	No
Prolonged bleeding	❍	❍
Palpable lymph nodes	❍	❍

Endocrine	Yes	No
Excessive thirst	❍	❍
Recent hair loss	❍	❍

Past or Present Medical Conditions

❍ None

GI

❍ Acid Reflux
❍ Barrett's Esophagus
❍ Cirrhosis ❍ Liver Disease
❍ Colon Cancer
❍ Colon Polyps
❍ Crohn's Disease
❍ Diverticulosis/itis
❍ Esophageal Stricture
❍ Gallstones
❍ Hemorrhoids
❍ Hepatitis ❑ A ❑ B ❑ C
❍ Hiatal Hernia
❍ H. pylori
❍ Irritable Bowel Syndrome
❍ Jaundice
❍ Pancreatitis
❍ Stomach Ulcer

GI cont.

❍ Ulcerative Colitis

Cardiac

❍ Atrial Fibrillation
❍ Congestive Heart Failure
❍ Coronary Artery Disease
❍ Heart Attack
❍ High Blood Pressure
❍ High Cholesterol
❍ Stroke/TIA

Other

❍ Alcohol Abuse
❍ Anemia
❍ Anxiety ❍ Depression
❍ Arthritis
❍ Asthma
❍ Blood Clot Where: _____
❍ Blood Transfusion

Other cont.

❍ Cancer Type: _____
❍ Chronic Lung Disease
❍ Diabetes
❍ Drug Dependence
❍ Endometriosis
❍ HIV
❍ Chronic Kidney Disease
❍ Kidney Stones
❍ Lupus ❍ Autoimmune Disorder
❍ Ovarian Cyst
❍ Psychiatric Disorder
❍ Seizures
❍ Sleep Apnea
❍ Thyroid Disease
❍ Tuberculosis
❍ Other: _____
_____
_____

Previous Procedures/Surgeries

❍ None

GI Procedures

❍ None	When ?
❍ EGD (upper scope)	_____
❍ Colonoscopy	_____
❍ Flexible Sigmoidoscopy	_____

GI Surgeries

❍ None	When ?
❍ Abdominal/Inguinal Hernia repair	_____
❍ Appendix removed	_____
❍ Colon surgery	_____
❍ Exploratory abdominal	_____
❍ Gallbladder surgery	_____
❍ Weight Loss Surgery	Type: _____
❍ Hemorrhoidectomy	_____
❍ Hiatal hernia repair	_____
❍ Stomach surgery	_____
❍ Surgery for bowel obstruction or adhesions	_____
❍ Other: _____	_____

Cardiac Surgeries/Procedures

❍ None	When?
❍ Angioplasty	_____
❍ Cardiac catheterization	_____
❍ Coronary bypass	_____
❍ Defibrillator placement	_____
❍ Pacemaker placement	_____
❍ Stent placement	_____
❍ Valve replacement	_____
❍ Heart surgery, other	_____

Other

❍ None	When?
❍ Bone marrow or organ transplant	_____
❍ C-section	_____
❍ Cataract surgery	_____
❍ Hysterectomy (with/without) ovaries removed	_____
❍ Laparoscopy	_____
❍ Tubal Ligation	_____
❍ Other: _____	_____

Family Medical History

❍ None ❍ Unknown ❍ Adopted

Diagnoses	Yes	No	If yes, list relative:	Age of Diagnosis
Reflux Disease	❍	❍	_____	_____
Celiac Disease	❍	❍	_____	_____
Colon Cancer	❍	❍	_____	_____
Colon Polyps	❍	❍	_____	_____
Crohn's Disease	❍	❍	_____	_____
Esophageal Cancer	❍	❍	_____	_____
Gastric Cancer	❍	❍	_____	_____
Liver Disease	❍	❍	_____	_____
Gallstones	❍	❍	_____	_____
Pancreatic Cancer	❍	❍	_____	_____
Pancreatitis	❍	❍	_____	_____
Ulcerative Colitis	❍	❍	_____	_____
Barrett's Esophagus	❍	❍	_____	_____

Social History

Occupation: _____ Number of Children: _____

Marital Status: ❍ Single ❍ Married ❍ Divorced ❍ Separated ❍ Widowed

Alcohol: ❍ None ❍ Rarely ❍ Daily Type: _____ # Drinks per Week: _____

Tobacco: ❍ Never ❍ Current ❍ Former

Type	Age Started	Age Quit	Quantity	Frequency

Drug Use: ❍ Never ❍ Current ❍ Former

Type	Quantity	Frequency	Quit

Caffeine: ❍ None

Type: _____ # Servings Daily _____

Other:

YES	NO	
❍	❍	Are you currently on any special diet or dietary restrictions? (Diabetic, low sodium, weight loss, low cholesterol, gluten free, lactose free, etc.)
❍	❍	Do you require assistance with daily living?