**Rossana Moura M.D., P.A.**
*Gastroenterology & Hepatology*
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# Patient Information

**Last Name:** _____ **First Name:** _____

**Date of Birth:** _____ **Legal Sex:** ☐F ☐M **Soc. Sec. #:** _____

**Cell #:** _____ **Home #:** _____

**Email:** _____@ ☐Gmail ☐Hotmail ☐Yahoo ☐AOL ☐Other: _____.com

**Address:** _____

**Street/APT. #.** **City** **State** **Zip Code**

**Ethnicity:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

**Race:** ☐Asian ☐Black/African American ☐White/Caucasian ☐Native American ☐Other: _____

**Primary Care Doctor Name:** _____ **Phone #:** _____

**Emergency Contact Name:** _____ **Relationship:** _____ **Phone #:** _____

**Pharmacy Name:** _____ **Pharmacy Phone #:** _____

**Reason for today's visits**: _____

## Permission to Disclose Health Information

**Leave a message on your answering machine at home or cell?** ☐**Yes** ☐**No**

**May we email results to your personal email address?** ☐**Yes** ☐**No**

**May we discuss your medical condition or results with any other member of your household?** ☐**Yes** ☐**No**

**Name:** _____**Relation:** _____**Phone#:** _____

**Name:** _____**Relation:** _____**Phone#:** _____

## Social History

**Marital Status:**

| | | | | | |
|---|---|---|---|---|---|
| ☐Married | ☐Single | ☐Divorced | ☐Separated | ☐Widowed | ☐Domestic Partner |

**Patient Occupation:**

| | | | | | |
|---|---|---|---|---|---|
| ☐Employed | ☐Self-Employed | ☐Un-Employed | ☐Student | ☐Retired | ☐Disabled |
| Type of Job: | | | | | |

**Tobacco:**

☐Never Smoked

☐Current Smoker: How Many Per Day? _____

☐Former Smoker: What Year Did You Quit? _____

**Alcohol:**

☐Don't Drink ☐Rarely ☐Socially ☐Daily

Type: ☐Wine ☐Beer ☐Liquor

Number Of Drinks Per Week: _____

**Illicit Drug Use:**

Have You Ever Used Drugs: ☐No ☐Yes

If Yes, What Type:

☐Marijuana ☐Cocaine ☐Crack Cocaine ☐Heroin

☐Narcotics Last Used:_____

**Tattoo:**

Do You Have Tattoos? ☐No ☐Yes

If Yes, How Many? _____

Year Of Oldest Tattoo: _____

**Patient Name: _____ Date of Birth: _____**

## Medications (Prescription and Over the Counter)

| Name | Strength | How often taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Allergies:_____**

_____

## Past or Present Medical Illnesses (Mark all that apply):

| | | | |
|---|---|---|---|
| ☐None | ☐Colon Polyps | ☐Hemorrhoids | ☐Osteoporosis<br>☐Osteopenia |
| ☐Acid Reflux | ☐Colon Cancer | ☐Hernia:<br>☐Inguinal ☐Umbilical ☐Hiatal | ☐Pancreatitis |
| ☐Anemia | ☐Depression | ☐Hepatitis: ☐A ☐B ☐C | ☐Paralysis |
| ☐Arthritis:<br>☐Osteoarthritis ☐Rheumatoid | ☐Diabetes | ☐High Blood Pressure | ☐Parkinson's Disease |
| ☐Asthma | ☐Diverticulitis | ☐High Cholesterol | ☐Pneumonia |
| ☐Bronchitis | ☐Endometriosis | ☐HIV/AIDS | ☐Rheumatic Fever |
| ☐COPD | ☐Fatty Liver | ☐Irritable Bowel:<br>☐Constipation ☐Diarrhea | ☐Seizures |
| ☐Cancer:<br>Type: _____ | ☐Fibromyalgia | ☐Kidney Stones | ☐Sleep Apnea |
| ☐Cirrhosis of Liver | ☐Gallstones | ☐Lactose Intolerance | ☐Stroke |
| ☐Colitis:<br>☐Ischemic ☐Ulcerative | ☐Glaucoma | ☐Macular Degeneration | ☐Thyroid Disease:<br>☐Low ☐High |
| ☐Crohn's Disease<br>☐Small Bowel ☐Large Bowel | ☐Heart Disease:<br>☐Heart Attack ☐Heart Murmur | ☐Migraines | ☐Ulcer:<br>☐Duodenal ☐Stomach |
| Other: | | | |

## Previous Surgeries/ Procedures (Mark all that apply):

| | | | |
|---|---|---|---|
| ☐None | ☐Colonoscopy<br>Year: _____ | ☐Heart Valve Replacement | ☐Prostate<br>☐Biopsy ☐Removal |
| ☐Appendix | ☐EGD/Upper Endoscopy<br>Year: _____ | ☐Joint:_____<br>☐Surgery ☐Replacement | ☐Stomach |
| ☐Back/Spine | Sigmoidoscopy<br>Year: _____ | ☐Kidney Removal<br>☐Right ☐Left | ☐Thyroid<br>☐Biopsy ☐Removal |
| ☐Blood Transfusion<br>When: _____ | ☐Gallbladder Removal | ☐Liver Biopsy<br>Year :_____ | ☐Tonsils |
| ☐Breast (☐Right ☐Left)<br>☐Biopsy ☐Lumpectomy<br>☐Cosmetic ☐Mastectomy | ☐Heart Bypass<br>☐Heart Stent | ☐Obesity Surgery:<br>☐Gastric Bypass ☐Gastric Sleeve<br>☐Tummy Tuck | ☐Transplant Surgery<br>Type: _____ |
| ☐C-Section | ☐Hemorrhoid Surgery | ☐Pacemaker | ☐Tubal Ligation |
| ☐Colon Resection | ☐Hernia Repair<br>☐Hiatal ☐Inguinal ☐Umbilical | ☐Hysterectomy<br>☐Partial ☐Total | ☐Vasectomy |
| ☐Defibrillator | Other: | | |

**Patient Name: _____ Date of Birth: _____**

## Family History

| | Father | Mother | Son | Daughter | Brother | Sister | Paternal Grandmother | Paternal Grandfather | Maternal Grandmother | Maternal Grandfather |
|---|---|---|---|---|---|---|---|---|---|---|
| Crohn's Disease | | | | | | | | | | |
| Ulcerative Colitis | | | | | | | | | | |
| Colon Cancer | | | | | | | | | | |
| Colon Polyp | | | | | | | | | | |
| Stomach Cancer | | | | | | | | | | |
| Liver Disease | | | | | | | | | | |
| Liver Cancer | | | | | | | | | | |
| Pancreatic Cancer | | | | | | | | | | |
| Other Types of Cancer: | | | | | | | | | | |

## Review of Systems (Mark all that apply):

| | |
|---|---|
| General | ☐Change In Appetite ☐Chills ☐Fever ☐Weight Gain ☐Weight Loss |
| Eyes | ☐Discharge ☐Pain ☐Redness |
| ENT | ☐Decreased Hearing ☐Decreased Smell ☐Ear Pain ☐Sore Throat ☐Nosebleed |
| Endocrine | ☐Excessive Sweating ☐Excessive Thirst |
| Respiratory | ☐Cough ☐Shortness Of Breath ☐Wheezing ☐Coughing Up Blood |
| Heart | ☐Chest Pain ☐Palpitations ☐Shortness Of Breath On Exertion |
| Gastrointestinal | ☐Abdominal Pain ☐Blood In Stool ☐Constipation ☐Diarrhea ☐Difficulty Swallowing ☐Heartburn ☐Nausea ☐Vomiting ☐Vomiting Blood |
| Genitourinary | ☐Blood In Urine ☐Frequent Urination ☐Painful Urination ☐Heavy Menstrual Periods |
| Musculoskeletal | ☐Back Problems ☐Joint Stiffness ☐Joint Pain ☐Leg Cramps ☐Muscle Aches |
| Skin | ☐Rash ☐Itching ☐Abnormal Moles |
| Neurologic | ☐Dizziness ☐Headaches ☐Loss Of Strength ☐Memory Loss ☐Seizures ☐Tremors ☐Paralysis |
| Psychiatric | ☐Depression ☐Anxiety ☐Stressors ☐Eating Disorder ☐Suicidal Thoughts |

**To the best of my knowledge, the questions on these forms have been answered accurately. I understand that providing incorrect information may be dangerous to my (or the patient's) health. It is my responsibility to inform Rossana Moura M.D., P.A. of any change in medical status.**

_____ _____

**Patient Signature or Legal Representative** **Date**

***Relationship to patient:** ☐**Parent** ☐**Legal Guardian** ☐**Other:** _____