MID STATE GASTROENTEROLOGY, LLC

Patient's Name: _____ Date: _____

Reason for visit? _____

Referring/Primary Care Physician: _____

Primary Pharmacy: Name /Location/Phone Number

_____

Secondary Pharmacy: Name/Location/Phone Number

_____

Preferred Lab Name/Location:_____

Please List ALL Current Medications and dosages:

Medication	Dosage	Medication	Dosage

Please List any Supplements you take:

_____

_____

_____

Allergies to Medications/ Latex: Yes ☐ No ☐

Explain: _____

Surgeries	Year	Reason/Diagnosis

	Y/N	Explain		Y/N	Explain
Last Colonoscopy or Pansigmoidoscopy			Gall Bladder Disease		
Last EGD			Gynecological/Breast Disease		
Last Rectal			Heart Disease/Arrythmias		
Anxiety Disorder			Hypercholesterolemia		
Arthritis			Hypertension		
Asthma			Kidney Disease		
COPD/Emphysema			Liver Disease		
Cancer			Neurological Disease		
Colitis/Crohn's			Osteoporosis/Osteopenia		
Coronary Artery Disease			Prostate Disease		
Depression (Psychological)			Reflux/GERD		
Dermatological Disease			Sleep Apnea		
Diabetes			Stroke		
Diverticulosis/Diverticulitis			Thyroid Disease		
Elevated Triglycerides			Tuberculosis		
Gall Bladder Disease					

Other Medical History:

Explain:

Social History

Occupation: _____

Do you drink alcohol now? Yes ☐ No ☐ Describe alcohol usage: Social Mild Moderate Heavy

Explain: _____

Do you currently smoke? Yes ☐ No ☐ If Yes:

How long have you smoked? _____ Since what age? _____ How many packs per day? _____

Did you ever smoke? Yes ☐ No ☐ If Yes:

When did you stop? _____ How many years did you smoke? _____

Have you now or ever used illicit drugs? Yes ☐ No ☐ What/When _____

Family History of Illness or Disease:

Family Member	Alive (Age)	Deceased (Age)	Illness/diseases/cause of death
Mother			
Maternal grandmother			
Maternal grandfather			
Father			
Paternal grandmother			
Paternal grandfather			
Sibling brother/sister			
Sibling brother/sister			
Sibling brother/sister			
Sibling brother/sister			
Child son/daughter			
Child son/daughter			
Child son/daughter			
Child son/daughter			

Family history of Colon Cancer: Yes ☐ No ☐ (who/age) _____

Family history of Colonic Polyps: Yes☐ No ☐ (who/age) _____

Family history of Colitis/Crohn's Disease: Yes ☐ No ☐ (type/who) _____

Other Family History:

_____

Completed by: _____ Relationship to patient: _____
(Please Sign)

_____

To be completed by the office:

Information Reviewed by: _____ Date: _____