Charlotte Gastroenterology & Hepatology

Date:_______________

MEDICAL HISTORY

Name:_________________________________ Address:____
Reason for Visit:____ Referred By:____________________________
DOB:_____________ Height:_____ Weight:______ Pharmacy and Phone#:_____________________________________

ALLERGIES:

Are you allergic to Latex? ( ) Yes ( ) No

Please list everything that you are allergic to **AND** the reaction (Ex: hives, rash, etc). If no allergies, please write "None".

____
____

MEDICATIONS (Prescription, Non-Prescription, Vitamins and Supplements):

Drug Name	Strength	Dose/Frequency	Last Taken
__________________________	_________	___________	___________
__________________________	_________	___________	___________
__________________________	_________	___________	___________
__________________________	_________	___________	___________
__________________________	_________	___________	___________
__________________________	_________	___________	___________
__________________________	_________	___________	___________

PAST MEDICAL/SURGICAL HISTORY (Check all that apply):

( ) Glaucoma
( ) Emphysema/COPD
( ) Home Oxygen
( ) Sleep Apnea
( ) CPAP/BIPAP
( ) TB
( ) Asthma
( ) Angina
( ) Heart Attack
( ) Heart Bypass Surgery
( ) Coronary Artery Disease

( ) Pacemaker
( ) Defibrillator
( ) Heart Murmur
( ) Mitral Valve Prolapse
( ) Heart Valve Replacement
( ) Endocarditis
( ) High Blood Pressure
( ) Bleeding Disorder
( ) Problems with Anesthesia
( ) Hepatitis
( ) Gallbladder Problems

( ) HIV
( ) MRSA
( ) Liver Disease
( ) Dialysis
( ) Kidney Failure
( ) Psychiatric History
Ex: depression/anxiety
( ) Constipation
( ) Nausea/Vomiting
( ) Diarrhea
( ) Hemorrhoids
( ) Rectal Bleeding

( ) Ulcerative Colitis
( ) Crohn's Disease
( ) Colon Polyps
( ) Swallowing Problems
( ) Ulcers
( ) GERD/Indigestion
( ) Seizure Disorder
( ) Stroke
( ) Thyroid Problems
( ) Diabetes
( ) Insulin ( ) Oral Meds
( ) Pregnant LMP_______

( ) Metal Prosthesis/Artificial Joints
Location___________________________

( ) Cancer
Location_____________________________

( ) Mobility Problems (Ex: Wheelchair, cane, artificial limb,etc)

( ) Other__________________________________
____

Surgeries/Procedures (Please list **ALL** you have had and the year performed. Indicate right or left side where applicable. Ex: Right knee replacement in 2005): ____
____
____
____
____

SOCIAL HISTORY

Employment/Occupation

Occupation___________________________ Employer____

Birthplace____________________________ Education______________________________ ( ) Retired ( ) Disabled

Marital Status

( ) Single ( ) Married ( ) Divorced ( ) Widowed

Children

( ) None Sons____ Daughters ____

Caffeine

( ) No ( ) Yes Type______ Amt__________

Alcohol

( ) None Type__________ Amt________ Freq___________

Tobacco

Smokes? ( ) Yes ( ) No ( ) Former

Type____________________

Packs/day________________

Yrs Smoked_______________

Yr Quit___________________

Ever Tried to Quit? ( ) Y es ( ) No

Smokeless Tobacco? ( ) Yes ( ) No ( ) Former

Type_________________________

Times Per Day________________

Yrs used______________________

Yr Quit_______________________

Ever Tried to Quit? ( ) Yes ( ) No

Tattoos ( ) Yes ( ) No **Body Piercings** ( ) Yes ( ) No

Dentures ( ) Yes ( ) No **Partials** ( ) Yes ( ) No **Loose/Missing Teeth** ( ) Yes ( ) No

Corrective Lenses ( ) Y es ( ) No ( ) Contacts **Hearing Aids** ( ) Yes ( ) No

Communication Barriers: ( ) Speech (Ex: Slurred, Aphasic, etc) ( ) Language _____________________

Recent Blood Transfusion ( ) Yes ( ) No **Recent Travel** ( ) Out of State ( ) Out of Country

FAMILY HISTORY

Please indicate which family members have any of the following. (Ex: Mother, Father, Sister, Brother)

Asthma____________________________________

Alcoholism_________________________________

Blood Disease______________________________

Cancer (type)______________________________

Colon Cancer_______________________________

Colon Polyps_______________________________

Crohn's Disease____________________________

Depression_________________________________

Diabetes___________________________________

Gallbladder Disease_________________________

GI Malignancies_____________________________

Hepatitis___________________________________

Heart Disease_______________________________

Hypertension________________________________

Irritable Bowel Syndrome_____________________

Liver Disease_______________________________

Obesity_____________________________________

Pancreas Problems___________________________

Ulcerative Colitis____________________________

Ulcer Problems______________________________

Problems with Anesthesia_____________________

Other (Indicate)______________________________

Signature:_____________________________________ **Date:**____________________________________