CHARLOTTE GASTROENTEROLOGY & HEPATOLOGY, P.L.L.C.

Date:______________

MEDICAL HISTORY

Name:______________________________ Contact Phone Number:____________________________

Name Preference:__________________________Address:____

Reason for Visit:_________________________________ Referred By (MD or PCP):_________________________

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".

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

Drug Name	Strength	Dose/Frequency	Last Taken
______________________	________	__________	__________
________________________	________	__________	__________
________________________	________	__________	__________
________________________	________	__________	__________
________________________	________	__________	__________
________________________	________	__________	__________
________________________	________	__________	__________
________________________	________	__________	__________

PAST MEDICAL HISTORY (Check all that apply):

( ) Barrett's esophagus
( ) Cancer ___________
( ) Celiac disease
( ) Colon polyps
( ) Crohn's Disease
( ) Diverticular Disease
( ) GERD
( ) Hepatitis/Liver Disease_______
( ) Irritable Bowel Syndrome
( ) Pancreatitis
( ) Peptic ulcer disease
( ) Ulcerative colitis
( ) Gallstones
( ) Varices, esophageal

( ) Alcoholism
( ) Anemia
( ) Arthritis
( ) Asthma
( ) Congestive heart failure
( ) COPD
( ) Coronary Artery Disease
( ) Depression/Anxiety
( ) Diabetes ( ) Insulin ( ) Oral
( ) High Cholesterol
( ) Emphysema
( ) Glaucoma

( ) Headache, migraine
( ) HIV
( ) High Blood Pressure
( ) Kidney Stones
( ) Parkinson disease
( ) Enlarged Prostate
( ) Renal disease
( ) Seizure disorder
( ) Sleep apnea - CPAP/BPAP
( ) Stroke
( ) Thyroid Disorder
( ) Tuberculosis
( ) Other_______________

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Other Information

( ) Home Oxygen
( ) Valve Replacement- Heart
( ) Endocarditis
( ) Defibrillator
( ) Metal Prosthesis/Artificial Joints
( ) Mobility problems, wheelchair/ artificial limbs
( ) MRSA
( ) Bleeding disorder
( ) Problems with anesthesia
( ) Kidney/Dialysis

Name:___________________
Date of Birth: _____________

PAST SURGICAL HISTORY (Check all that apply):

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):

( ) Appendectomy_________
(Appendix removed)
( ) Back Surgery_________
( ) Bilateral tubal ligation_______
( ) Blood transfusion _________
( ) CABG _________
( ) Cardiac pacemaker _________
( ) Cholecystectomy_________
(Gallbladder removed)
( ) Colectomy_________

( ) Colonoscopy_________
( ) Coronary Stents________
( ) EGD _________
(Upper Endoscopy)
( ) ERCP
( ) EUS
( ) Flexible Sigmoidoscopy
( ) Gastric bypass _________
( ) Hernia repair _________
( ) Hip replacement_______
( ) Hysterectomy _________
( ) Knee replacement ________

( ) Liver biopsy_________
( ) Mastectomy_________
( ) Small bowel resection_________
( ) Thyroidectomy_________
( ) Tonsillectomy____________
( ) TURP_________
( ) Vasectomy_________
( ) Other_______________
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Employment/Occupation

Occupation_______________________ Employer____
Birthplace________________________ Education_________________________ ( ) Retired ( ) Disabled

Marital Status

( ) Single ( ) Married ( ) Divorced ( ) Widowed
Spouse/Significant Other's Name_________________

Children

( ) None Sons____ Daughters ____

Caffeine

( ) No ( ) Yes Type_____ Amt_________

Alcohol

( ) None Type_________ Amt_______ Freq__________

Tobacco

Smokes? ( ) Yes ( ) No ( ) Former
Type___________________
Packs/day_______________
Yrs Smoked______________
Age Quit__________________
Ever Tried to Quit? ( ) Yes ( ) No

Smokeless Tobacco? ( ) Yes ( ) No ( ) Former
Type________________________
Times Per Day_______________
Yrs used_____________________
Age 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 ( ) Yes ( ) 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

Name:___________________
Date of Birth: _____________

FAMILY HISTORY

Mother: ( ) Alive ( ) Deceased Age_____ Father: ( ) Alive ( ) Deceased Age_____

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

GI FAMILY HISTORY

	Mother	Father	Brother	Sister
Barrett's Esophagus	( )	( )	( )	( )
Colon Cancer	( )	( )	( )	( )
Celiac disease	( )	( )	( )	( )
Colitis	( )	( )	( )	( )
Colon polyps	( )	( )	( )	( )
Crohn's disease	( )	( )	( )	( )
Diverticular disease	( )	( )	( )	( )
Gallbladder disease	( )	( )	( )	( )
Irritable bowel syndrome	( )	( )	( )	( )
Liver disease __________	( )	( )	( )	( )
Peptic ulcer disease	( )	( )	( )	( )
Ulcerative colitis	( )	( )	( )	( )
Other GI Cancers:				
Esophageal	( )	( )	( )	( )
Pancreatic	( )	( )	( )	( )
Stomach	( )	( )	( )	( )
Liver	( )	( )	( )	( )
Genetic Cancer Conditions	( )	( )	( )	( )

None of the Above ( )

OTHER FAMILY HISTORY

	Mother	Father	Brother	Sister
Alcoholism	( )	( )	( )	( )
Alzheimer's disease	( )	( )	( )	( )
Arthritis	( )	( )	( )	( )
Asthma	( )	( )	( )	( )
Blood Disorder	( )	( )	( )	( )
Cancer ________________	( )	( )	( )	( )
Coronary artery disease	( )	( )	( )	( )
High Cholesterol	( )	( )	( )	( )
Genetic disease	( )	( )	( )	( )
High Blood Pressure	( )	( )	( )	( )
Diabetes	( )	( )	( )	( )
Cardiovascular disease	( )	( )	( )	( )
Migraines	( )	( )	( )	( )
Obesity	( )	( )	( )	( )
Osteoporosis	( )	( )	( )	( )
Kidney disease	( )	( )	( )	( )
Seizure disorder	( )	( )	( )	( )
Stroke	( )	( )	( )	( )
Thyroid disorder	( )	( )	( )	( )
Other	( )	( )	( )	( )

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Signature:______________________________________ Date:____