CHARLOTTE
GASTROENTEROLOGY &
HEPATOLOGY

Patient Scheduling Form

Name

DOB

Phone

Address

City

Zip

Sex ◯ Male ◯ Female

Preferred Language: ◯ English ◯ Spanish Other

Primary Physician Name

Date of Last Exam

Office Name

Date of Last Exam

GENERAL HEALTH INFORMATION

Height

Weight

Please check all statements that apply to you

- ◯ I have children.
- ◯ I have tattoo(s)
- ◯ I have body piercings.
- ◯ I have dentures.
- ◯ I have partials.
- ◯ I have loose/missing teeth.
- ◯ I use corrective lenses.
- ◯ I have hearing aids.
- ◯ I have communication barriers (ex. language or speech: slurred, aphasic)
- ◯ I've had a recent blood transfusion.
- ◯ I have recently traveled (domestic or international).
- ◯ None of these statements apply to me

Do you consume Caffeine?

- ◯ Yes
- ◯ No

Do you consume Alcohol?

- ◯ Yes
- ◯ No

Do you smoke?

- ◯ Yes No
- ◯ Former
- ◯

Do you use smokeless tobacco?

- ◯ Yes
- ◯ No
- ◯ Former

PERSONAL MEDICAL HISTORY

	Yes	No
Have you ever had a colonoscopy?	◯	◯
If so, when? _____		
Do you have relatives with colon cancer?	◯	◯
If so, who? _____		
Do you have Congestive Heart Failure?	◯	◯
Do you have Coronary Artery Disease, Angina, or history of Heart Attack?	◯	◯
Do you have Valvular Heart Disease, or Artificial heart valve?	◯	◯
Do you have Emphysema, COPD, Asthma, or Bronchitis requiring regular medical therapy?	◯	◯
Do you have Sleep Apnea	◯	◯
Do you have Kidney Disease?	◯	◯
Do you have history of a Stroke?	◯	◯
Do you have Diabetes?	◯	◯
Have you had a joint replacement within the last year?	◯	◯
Have you ever had a complication with anesthesia?	◯	◯
Do you have heartburn more than twice a week?	◯	◯
Do you see blood in your bowel movements?	◯	◯
Do you have frequent constipation or diarrhea?	◯	◯

PERSONAL MEDICAL AND SURGICAL HISTORY

Past medical History (Select all that apply)

- ◯ Alcoholism
- ◯ Anemia
- ◯ Arthritis
- ◯ Barrett's esophagus
- ◯ Cancer
- ◯ Celiac disease
- ◯ Colon polyps
- ◯ Congestive heart failure
- ◯ Coronary artery disease
- ◯ Crohn's disease
- ◯ Depression/anxiety
- ◯ Diverticular disease
- ◯ Enlarged prostate
- ◯ Gallstones
- ◯ GERD
- ◯ Glaucoma
- ◯ Headache / migraine
- ◯ High blood pressure
- ◯ High cholesterol
- ◯ HIV
- ◯ Irritable bowel syndrome
- ◯ Kidney stones
- ◯ Pancreatitis
- ◯ Parkinsons disease
- ◯ Peptic ulcer disease
- ◯ Renal disease
- ◯ Seizure disorder
- ◯ Stroke
- ◯ Thyroid Disease
- ◯ Tuberculosis
- ◯ Ulcerative Colitis
- ◯ Varices esophageal
- ◯ None of these apply
- ◯ Other

[ ]

Past Surgical History

- ○ Bleeding Disorder
- ○ Defibrillator
- ○ Endocarditis
- ○ Home Oxygen
- ○ Kidney Disease/Dialysis
- ○ Metal Prosthetic/Artificial Joints
- ○ Mobility Problems, Wheelchair/Artificial Limbs
- ○ MRSA
- ○ Problems with Anesthesia
- ○ Heart Valve Replacement
- ○ None of the above
- ○ Appendectomy
- ○ Back surgery
- ○ Bilateral tubal ligation
- ○ Blood transfusion
- ○ CABG
- ○ Cardiac pacemaker
- ○ Cholecystectomy (gallbladder)
- ○ Colectomy
- ○ Colonoscopy
- ○ Coronary stents
- ○ EGD (upper endoscopy)
- ○ ERCP
- ○ Vasectomy
- ○ Other
- ○ EUS
- ○ Flexible Sigmoidoscopy
- ○ Gastric bypass
- ○ Hernia repair
- ○ Hip replacement
- ○ Hysterectomy
- ○ Knee Replacement
- ○ Liver biopsy
- ○ Mastectomy
- ○ Small bowl resection
- ○ Thyroidectomy
- ○ Tonsillectomy
- ○ TURP

FAMILY MEDICAL HISTORY

GI Family Medical History (Select All that apply)

	MOTHER	FATHER	SISTER	BROTHER
Barrett's Esophagus	○	○	○	○
Colon Cancer	○	○	○	○
Colitis	○	○	○	○
Colon Polyps Chron's	○	○	○	○
Disease Gallbladder	○	○	○	○
Disease Irritable bowel	○	○	○	○
syndrome Liver Disease	○	○	○	○
Peptic ulcer disease	○	○	○	○
Ulcerative Colitis	○	○	○	○
Esophageal Cancer	○	○	○	○
Pancreatic Cancer	○	○	○	○
Stomach Cancer	○	○	○	○
Liver Cancer	○	○	○	○
Genetic Cancer Conditions	○	○	○	○

OTHER FAMILY MEDICAL HISTORY

GI Family Medical History (Select All that apply)

	MOTHER	FATHER	SISTER	BROTHER
Alcoholism	○	○	○	○
Alzheimer's disease	○	○	○	○
Arthritis	○	○	○	○
Asthma	○	○	○	○
Blood Disorder	○	○	○	○
Coronary artery disease	○	○	○	○
High Cholesterol	○	○	○	○
Genetic disease	○	○	○	○
High Blood Pressure	○	○	○	○
Diabetes	○	○	○	○
Cardiovascular disease	○	○	○	○
Migraines	○	○	○	○
Obesity	○	○	○	○
Osteoporosis	○	○	○	○
Kidney disorder	○	○	○	○
Seizure disorder	○	○	○	○
Stroke	○	○	○	○
Thyroid disorder	○	○	○	○

Please list other family history that is not listed above:

ALLERGIES:

Are you allergic to latex?

○ Yes

○ No

Please list everything that you are allergic to AND the reaction (ex. hives, rash, etc);

MEDICATIONS

Please list all medications you are currently taking:

Patient Signature: Date: