

**Gastroenterology Specialists of Middle Tennessee
at TriStar Southern Hills**

Patient History

Please answer to the best of your ability, as this will help us to provide you with more efficient and complete healthcare

Name _____ Age _____ Today's date _____

Would you prefer that our staff call you by your:

first name last name something else

Were you referred? No Yes - by whom?

Please list all of your current physicians and their specialties:

What is the main reason for today's visit:

Do you currently have or have you had in the past any medical problems?

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Anorexia/bulimia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke | <input type="checkbox"/> H. pylori |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Irritable bowel syndrome |
| <input type="checkbox"/> Blood clot in legs/lungs | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Acid reflux/heartburn | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Cancer
type _____ | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Colon polyps | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Diverticular disease | | |

Any other problems not listed above? _____

Have you undergone colonoscopy? No Yes
When _____
Where/by whom? _____

Have you undergone upper endoscopy? No Yes
When _____
Where/by whom? _____

Have you ever had surgery?

- | | | | |
|---|---------------------------------------|---|--|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Heart bypass | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Colon surgery | <input type="checkbox"/> Heart stent | <input type="checkbox"/> Kidney surgery | <input type="checkbox"/> Splenectomy |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Heart valve | <input type="checkbox"/> Lap band | <input type="checkbox"/> Stomach surgery |
| <input type="checkbox"/> Gastric bypass | <input type="checkbox"/> Hernia | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Tubal ligation |

Any other surgery not listed above? _____

Are you allergic to, or have you had a bad reaction to any medications? No Yes – please list

Are you are taking any blood thinners? No Yes – please list

Dr. who prescribes this medication _____

Please list all current medications (including OTC medication/supplements see attached list

Social History

[] Single [] Married [] Widowed [] Divorced [] Separated [] Partner

Occupation: _____ [] Retired [] Disabled

Tobacco: [] smoke [] chew [] dip? [] No [] Yes – How much? _____

Alcohol: Drink [] beer [] wine [] liquor? [] No [] Yes – How much? _____

Do you use or have you in the past used drugs? [] No [] Yes – Specify _____

Family History

Has any close family member had any of the following?

	<u>Who?</u>		<u>Who?</u>
[] Colon polyps	_____	[] Crohn's disease	_____
[] Colon cancer	_____	[] Ulcerative colitis	_____
[] Esophageal cancer	_____	[] Gallbladder disease	_____
[] Pancreatic cancer	_____	[] Liver disease	_____
[] Stomach cancer	_____	[] Problems with anesthesia	_____
[] Alcoholism	_____	[] Problems with bleeding	_____

Are you currently experiencing any problems with (check any that apply):

- | | | |
|------------------------|-------------------------|---------------------------|
| [] Abdominal pain | [] Eye pain | [] Muscle pain |
| [] Nausea, vomiting | [] Vision | [] Joint pain |
| [] Increased gas | [] Mouth sores | [] Skin rash |
| [] Swallowing | [] Nosebleeds | [] Easy bruising |
| [] Heartburn | [] Hearing | [] Dizziness |
| [] Reflux | [] Sore throat | [] Headache |
| [] Diarrhea | [] Sinuses | [] Weakness |
| [] Constipation | [] Leg swelling | [] Anxiety |
| [] Rectal bleeding | [] Palpitations | [] Depression |
| [] Fecal incontinence | [] Chest pain | [] Stress |
| [] Black stool | [] Wheezing | [] Intolerance to cold |
| [] Greasy stool | [] Shortness of breath | [] Intolerance to heat |
| [] Jaundice | [] Cough | [] Unusual bleeding |
| [] Fever | [] Urinary burning | [] Enlarged lymph glands |
| [] Weight gain | [] Dark urine | |
| [] Weight loss | [] Urine incontinence | |
| [] Fatigue | [] Starting stream | |

women

[] Vaginal bleeding

Are you/could you be pregnant?

[] No [] Yes

[] last period _____ or [] menopause

When did you last have:

Blood test _____

Upper GI X ray _____

Abdominal ultrasound _____

Barium enema _____

Abdominal CT scan _____