

Middlesex Gastroenterology, P.C.
Patient Information

Today's Date: _____

Name: _____ **Date of Birth:** _____

Primary Care Physician: _____

Chief Complaint:

Medical History:

Do you have or have had any of these symptoms?

Yes No

<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Heart Burn
<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disease
<input type="checkbox"/>	<input type="checkbox"/>	Gallstones
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Change in Bowel Habits
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Crohn's/colitis
<input type="checkbox"/>	<input type="checkbox"/>	Diverticulosis/itis
<input type="checkbox"/>	<input type="checkbox"/>	Rectal Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids

Current Medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Any Drug/Food Allergies:(Including IV contrast)

Social History:

Please Circle when applicable:

Single/Married/Widowed/Divorced ? children? if any: _____ (#)

Do you smoke? Yes/No/Quit (circle) If Yes/Quit _____ packs/day?

You drink _____caffeinated drinks/day? coffee/tea? How many cups/day? _____

Alcohol use: Beer/wine/other How many drinks day/week? _____

Name: _____ DOB: _____

Past Medical History (Check all that apply):

<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> Lung disorders
<input type="checkbox"/> Angina	<input type="checkbox"/> CVA	<input type="checkbox"/> Lupus
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> Lyme Disease
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Cardiac Problems	<input type="checkbox"/> Myocardial infarction
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Obesity
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gastritis	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Back pain	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Panic attacks
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Gout	<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Blood Clots/DVT	<input type="checkbox"/> Headache	<input type="checkbox"/> Polymyalgia / Fibromyalgia
<input type="checkbox"/> Cancer-Breast	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Cancer-Colon	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pulmonary Infection
<input type="checkbox"/> Cancer-Leukemia	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Renal failure
<input type="checkbox"/> Cancer-Lung	<input type="checkbox"/> HIV	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Cancer-Lymphoma	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Seizures
<input type="checkbox"/> Cancer-Prostate	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Cancer-Skin	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Spinal stenosis
<input type="checkbox"/> Colon polyps	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Strokes/CVA
<input type="checkbox"/> COPD	<input type="checkbox"/> Impotence	<input type="checkbox"/> Vascular Problems/Circ
	<input type="checkbox"/> Lumbar disk disease	<input type="checkbox"/> Vertigo

Other: _____

Surgical History:

Please note here if you have any heart related issues such as AICD or Pacemaker.

Also please let us know if you have ever had any problems with anesthesia or conscious sedation: _____

Name: _____ DOB: _____

Please Circle when applicable:

Family History:

Is your mother – living/deceased? Cause of death? _____ age _____

Is your father – living/deceased? Cause of death? _____ age _____

How many siblings do you have?

Brothers _____ - living/deceased? Cause of death? _____

Sisters _____ - living/deceased? Cause of death? _____

Any Family History of:

Yes No

<input type="checkbox"/>	<input type="checkbox"/>	Celiac Disease	If yes, who? _____
<input type="checkbox"/>	<input type="checkbox"/>	GERD	If yes, who? _____
<input type="checkbox"/>	<input type="checkbox"/>	Barrett's	If yes, who? _____
<input type="checkbox"/>	<input type="checkbox"/>	Esophageal Cancer	If yes, who? _____
<input type="checkbox"/>	<input type="checkbox"/>	Crohn's/Colitis	If yes, who? _____
<input type="checkbox"/>	<input type="checkbox"/>	Colon Polyps	If yes, who? _____
<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer	If yes, who? _____
<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis of the Liver	If yes, who? _____
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	If yes, who? _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B, or C	If yes, who? _____

Cancer (Other) Please Specify: _____