Atlantic Gastroenterology, P.A.
Atlantic Gastroenterology Endoscopy Center
Personal History

Last Name _____ **First Name**_____

Age _____ **Date of Birth** _____ **Race** _____ **Sex** _____ **Wt**_____

Primary Physician_____ **Referring Physician**_____

Chief complaint(s): (Check all that apply)

O Heartburn O Weight gain/loss O Screening Colonscopy O Rectal Bleeding O Anemia
O Abdominal Pain O Bloating O Diarrhea O Blood in Stool O Hepatitis
O Nausea/Vomiting O Gastric O Family History O Trouble Swallowing O Abn. Liver
O Vomiting Blood Bypass Screening of Colon Cancer O Constipation Enzymes
Other: _____

Current/Past Medical History (Check if you have):

Cardio-Pulmonary: O Asthma O Emphysema O High Blood Pressure O Sleep Apnea with CPAP
O COPD O Heart Disease O High Cholesterol O Lung Cancer
O CHF O Heart Attack ____yr. O Pneumonia O Tuberculosis

Gastrointestinal: O Barrett's Esophagus O Colon Polyps O Diverticulosis O Liver Disease O Ulcer
O Cirrhosis O Colon/Gastric CA O Hepatitis O Pancreatitis
O Colitis O Crohn's O Irritable bowel O Reflux

Hematology: O Anemia O Bleeding disorders O Use blood thinners: (circle one) Coumadin/Plavix/Aspirin

Endocrine/Renal: O Diabetes O Dialysis O Kidney Failure O Kidney Stone O Thyroid Disorder

Muscular/Skeletal: O Arthritis O Fibromyalgia

Neurological: O Dementia O Depression O Seizures O Stroke ____yr

Cancer: O Breast ____L____R O Colon/Gastric O Prostate O Leukemia/Lymphoma O Pancreatic

Past Surgical/ Procedural History (Check if you have):

GI Surgeries		Cardiac Surgeries	Reproductive/Urinary Surgeries	
O Appendectomy	O Gastric Bypass	O Cardiac Bypass _____yr	O C- Section	O Kidney Stones
O Cholecystectomy	O Hernia Repair	O Carotid Endarectomy	O Hysterectomy	O Tubal Ligation
(Gallbladder Surgery)	O Hemorrhoidectomy	O Coronary Catheterization	O Mastectomy _____Rt _____Lt	
O Colonoscopy _____yr	O Nissen Fundoplication	O Defibrillator/Pacemaker	O Prostatectomy	
O Colon resection	O Upper Endoscopy ___ yr		O Kidney Removal	

Other: O Cataract O Carpel Tunnel O Joint Replacement O Tonsillectomy O Back Surgery

_____

Allergies: (Check if you have): O None O IV Dye _____ reaction O Fentanyl _____reaction
O Versed _____reaction O Novocain _____ reaction Any reaction to Anesthesia in past? O Yes O No
reaction: _____ Other Allergies_____

Name of Medication	Dosage/Frequency	Name of Medication	Dosage/Frequency

Family History (List medical problems of relatives):

Father: _____ Mother: _____
Brothers/Sisters:_____
Family History of Colon Cancer O Yes O No Who: _____ Age of Diagnosis: _____
Family History of Colon Polyps O Yes O No Who: _____ Age of Diagnosis: _____
Family History of (Circle one) Crohn's, Ulcerative Colitis, and Liver Disease Who: _____Age: ___
Marital Status: O Single O Separated O Divorced O Married O Widowed
Children: O Yes O No Ages_____

Social History

Tobacco: O Yes O No Daily Usage: _____

Alcohol: O Yes O No Daily Usage: _____

Recreational Drugs: O Yes O No Type: _____

Communication Difficulties: O Vision O Hard of Hearing O Speech O Non-English Speaking

Occupational History

Current Employment: _____ Past Employment: _____

Review of Systems and Symptoms:

Check each box that applies and explain to the right, accurately describe your symptoms:

Yes	No	Constitutional
O	O	Weight Loss
O	O	Loss of Appetite
O	O	Fever
		Other: _____
		Eyes, Ear, Nose, and Throat
O	O	Glaucoma
O	O	Vision Loss
O	O	Hearing Loss
O	O	Difficulty/Pain in Swallowing
		Other: _____
		Pulmonary
O	O	Shortness of Breath
O	O	Chronic Cough
O	O	Tuberculosis
		Other: _____
		Cardiology
O	O	Chest Pain
O	O	Leg Pain with walking
O	O	Irregular Heart Beat
O	O	Heart Murmur
O	O	Venous Insufficiency
		Other: _____
		Gastrointestinal
O	O	Abdominal Pain
O	O	Gallstones
O	O	Jaundice
O	O	Nausea/Vomiting
O	O	Black Stools
O	O	Blood in Stool
O	O	Constipation
O	O	Diarrhea
O	O	Heart Burn/ Reflux
		Other: _____

Yes	No	Neurological
O	O	Headaches
O	O	TIA
O	O	Loss of Memory
O	O	Dementia
		Other: _____
		Psychiatric
O	O	Anxiety
O	O	Depression
O	O	Bipolar Disease
		Other: _____
		Musculoskeletal
O	O	Arthritis
O	O	Fibromyalgia
		Other: _____
		Hematology
O	O	Blood Transfusion
O	O	Easy Bruising/Bleeding
		Other: _____
		Genitourinary
O	O	Urinary Tract Infection
O	O	Sexually Transmitted Disease
O	O	Blood in Urine
O	O	Incontinence
		Other: _____
		Skin
O	O	Psoriasis
O	O	Rash
O	O	Skin Cancer/ Melanoma
		Other: _____
		Infectious
O	O	Hepatitis B or C
O	O	HIV/AIDS
		Other: _____

Patient Signature: _____ Date: _____

For AG staff only- Place date of history reviewed and initials.

History Reviewed	*Initials*	*History Reviewed*	*Initials*	*History Reviewed*	*Initials*

For AGEC Staff only- Place the date, procedure, and initials of review below

Date/Procedure	*Initials*	*Date/procedure*	*Initials*	*Date/procedure*	*Initials*