GATGI
Gastroenterology Associates of Tidewater

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Patient Name: _____ **DOB**: _____ **Date**: _____

Who referred you to us? ☐PCP (family doctor) _____ ☐Dr._____

☐Family friend_____ ☐Phone book ☐Internet Other_____

What is the main reason for your visit today? ☐Reflux or heartburn ☐Difficulty swallowing ☐Abdominal pain ☐Anemia ☐Nausea ☐Vomiting ☐Gas ☐Blood in stool ☐Constipation ☐Diarrhea ☐Abnormal liver tests ☐Hepatitis C ☐Hepatitis B ☐Celiac disease ☐Screening for colon cancer (colonoscopy) ☐Abnormal CT or x-ray result Other (list): _____

Please list all medical conditions: ☐High BP (even if treated) ☐Diabetes ☐Heart attack or angina ☐Asthma/COPD ☐Sleep apnea ☐Congestive heart failure ☐Bleeding disorder ☐Other (list):_____

Please list all medications as well as dosages:

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

Do you take any pain meds (NSAIDs) or blood thinners (e.g. Coumadin, Plavix, Aspirin, Advil/Motrin/Ibuprofen, Aleve/Naprosyn, BC or Goody Powder, arthritis meds, etc)? ☐Yes ☐No If yes, please list or circle: _____

ALLERGIES/INTOLERANCES: ☐None ☐Yes (Please list along with what type of reaction) ☐Penicillin ☐Sulfa ☐ Seafood ☐Iodine/Contrast/Dye ☐Anesthesia Other _____

Social History ☐Yes ☐No Tobacco Use: ☐Chew ☐Smoke, duration _____, amount_____, quit _____

☐Yes ☐No Alcohol use: Type and frequency _____

☐Yes ☐No Drug use (illegal): Type and frequency _____

Married, for how long? _____ ☐Divorced ☐Single

Occupation: _____ ☐Retired: _____

Any previous GI evaluation? ☐Yes ☐No If so, by whom? _____, City _____, State_____

☐Upper GI x-ray ☐EGD (upper endoscopy) ☐Small bowel x-ray ☐Camera Pill Examination ☐Sigmoidoscopy ☐Barium enema ☐Colonoscopy Other (list): _____

Any recent (within 1 year) diagnostic tests (e.g. CT scan, ultrasound, blood tests-circle appropriate option)? ☐Yes ☐No
If so, where (name of lab or hospital) _____ and when _____

Family Medical History: Have any of your first-degree relatives (father, mother, brother, sisters, children) been diagnosed with:

☐Yes ☐No Colon polyps or colon cancer Relationship: _____

☐Yes ☐No Familial polyposis coli Relationship: _____

☐Yes ☐No Ulcerative colitis or Crohn's disease Relationship: _____

☐Yes ☐No GI cancer (stomach, liver, or pancreas) Relationship: _____

☐Yes ☐No Liver disease or hepatitis Relationship: _____

Previous operations or surgeries: (Please list year and any pertinent information regarding surgery)

SURGERY	YEAR	NOTES	SURGERY	YEAR	NOTES
☐Gallbladder:	_____	_____	☐Heart bypass/stent	_____	_____
☐Stomach (gastric)	_____	_____	☐Pacemaker	_____	_____
☐Small bowel/Colon	_____	_____	☐Heart Valve	_____	_____
☐Hysterectomy/Ovary	_____	_____	☐Vascular	_____	_____
☐Appendix	_____	_____	☐Other	_____	_____

REVIEW OF GENERAL HEALTH

Patient Name: _____ **DOB**: _____ **Date**: _____

Please fill out the information below regarding your clinical condition by checking yes or no.

Upper GI Symptoms

___Yes ___No Heartburn
___Yes ___No Acid regurgitation
___Yes ___No Nighttime regurgitation
___Yes ___No Erosion of tooth enamel (caries)
___Yes ___No Cough or wheezing
___Yes ___No Difficulty swallowing
___Yes ___No Painful swallowing
___Yes ___No Lump in throat
___Yes ___No Chest pain
___Yes ___No Nausea
___Yes ___No Vomiting
___Yes ___No Blood in vomit
___Yes ___No Abdominal pain

Lower GI Problems

___Yes ___No Ulcerative colitis
___Yes ___No Crohn's disease
___Yes ___No Colon polyp
___Yes ___No Colon cancer
___Yes ___No Diverticulosis/Diverticulitis
___Yes ___No Bloating
___Yes ___No Excessive gas
___Yes ___No Milk/Dairy intolerance
___Yes ___No Diarrhea
___Yes ___No Bloody diarrhea
___Yes ___No Oil in stool
___Yes ___No Fecal incontinence
___Yes ___No Constipation
___Yes ___No Laxative use
___Yes ___No Narrow stool caliber
___Yes ___No Mucus in stool
___Yes ___No Anal fistula
___Yes ___No Hemorrhoids
___Yes ___No Anal tear (fissure)
___Yes ___No Rectal bleeding

Liver Problems

___Yes ___No Jaundice
___Yes ___No Hepatitis A
___Yes ___No Hepatitis B
___Yes ___No Hepatitis C
___Yes ___No V drug use
___Yes ___No Blood transfusion
___Yes ___No Gallbladder disease
___Yes ___No Light colored stool
___Yes ___No Abnormal liver enzymes

Cardiac/Respiratory Problems-- underline

___Yes ___No Taking blood thinners
___Yes ___No Mitral valve prolapse
___Yes ___No Artificial heart valve
___Yes ___No History of rheumatic heart disease
___Yes ___No Take antibiotics for dental work
___Yes ___No Sleep apnea
___Yes ___No Use CPAP
___Yes ___No Loud snoring
___Yes ___No Swelling of legs
___Yes ___No Shortness of breath

Blood Disorders

___Yes ___No Excessive bleeding
___Yes ___No History of blood clots (excessive clotting)
___Yes ___No Anemia (low blood count)

Endocrine Problems

___Yes ___No Thyroid disease
___Yes ___No Diabetes
___Yes ___No Excessive cold or heat intolerance

Neurologic or Psychiatric Disorders

___Yes ___No Depression
___Yes ___No Suicide attempt
___Yes ___No Anxiety
___Yes ___No Panic attacks
___Yes ___No Anorexia
___Yes ___No Bulimia
___Yes ___No Drug addiction
___Yes ___No Seizures
___Yes ___No Stroke/TIA

General

___Yes ___No Skin rash
___Yes ___No Fever
___Yes ___No Itching
___Yes ___No Weight loss
___Yes ___No Weight gain
___Yes ___No Joint pain
___Yes ___No Joint swelling
___Yes ___No Back pain
___Yes ___No Foreign travel
___Yes ___No Recent antibiotic use
___Yes ___No HIV infection

Thank you for filling out this questionnaire. With this information, we will do our best to diagnose your condition promptly. Following your consultation you will receive instructions from our office assistants regarding procedure preparations (if recommended) and educational literature (if available) concerning your diagnosis.

Patient signature _____ Date: _____