Lubbock Gastroenterology

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Date: _____ Name: _____ Phone number: _____DOB: _____

Reason for Visit:_____

☐ Married ☐ Single ☐ Divorced Number of Children: _____ Occupation: _____ Education: _____

Emergency Contact/ MPOA:_____ Phone Number:_____

Allergies/Reaction: (Please list) **NO** Medication Allergies: ◯ **Latex:** No **Metal:** No **Contrast Dye**: No

Medications/Strength/How often: **NO** Home Medications: ◯

Check those that apply:

☐ Abdominal Pain	☐ Regurgitation	☐ Diarrhea	☐ Constipation	☐ Appetite Changes
☐ Heartburn	☐ Nausea Vomiting	☐ Weight Loss	☐ Fever	☐ Jaundice
☐ Gallstones	☐ Swallowing Difficulty/Pain	☐ Anemia	☐ Bloating	☐ Polyps

Please list the top three symptoms from above that you are currently experiencing:

1._____ 2._____ 3._____

Diarrhea? Select One Frequency:_____

Have you ever had a colonoscopy? ☐ Yes ☐ No If yes, When and where:_____

Do you have a history of colon polyps? ☐ Yes ☐ No If yes, How many:_____

Family History of Colon Cancer? ☐ Yes ☐ No If yes, Who:_____

Do you have hemorrhoids? ☐ Yes ☐ No If Yes, do they bother you now? ☐Yes ☐No

Do you have acid reflux? ☐ Yes ☐ No If yes, is it controlled by Meds? ☐Yes ☐No

Have you ever been diagnosed with Hepatitis? ☐ Yes ☐ No If Yes, Which type: _____

Do you Drink Alcohol or Beer? ☐Yes ☐No ☐Past If Yes, What Kind? ☐Beer ☐Wine Other_____ How Often?_____

Do you use tobacco? ☐Yes ☐No ☐Past If Yes, What Kind? ☐Cigarettes ☐Vape ☐Chew How many years_____

Packs Per Day_____

Do you use Recreational Drugs? ☐Yes ☐No ☐Past If Yes/Past, What Kind?_____ Last Use:_____

Do you use IV Drugs? ☐Yes ☐No ☐Past If Yes/Past What Kind?_____ Last Use:_____

Do you tire easily? ☐Yes ☐No Do you use ambulatory assistive devices? ☐NO ☐Cane ☐Walker ☐Wheelchair/Scooter

Are you able to walk 2 blocks? ☐Yes ☐No Climb a flight of stairs? ☐Yes ☐No Run a short Distance? ☐Yes ☐No

Are you Physically active? ☐Yes ☐No Recent weight loss? ☐Yes ☐No Become short of breath easily? ☐Yes ☐No

Do you need help dressing? ☐Yes ☐No Any recent falls? ☐Yes ☐No Have chest pain with activity? ☐Yes ☐No

Do you wear: ☐ Glasses ☐ Contacts ☐ Hearing Aid

Please Mark all pre-existing conditions that apply to YOU: (check if applicable)

Eyes
- ☐ Cataract
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Yellow Eyes

Cardiovascular
- ☐ Aneurysm
- ☐ Chest pain
- ☐ CHF(Heart Failure)
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heartbeat(SVT, A-fib)
- ☐ Mitral Valve
- ☐ Pacemaker/Defibrillator
- ☐ Peripheral Vascular Disease
- ☐ Phlebitis/Blood Clots
- ☐ Heart Surgery/ Stents
- ☐ Raynaud's

Other:_____

Respiratory
- ☐ Asthma use inhaler ☐Yes ☐No
- ☐ COPD use inhaler ☐Yes ☐No
- ☐ Cystic Fibrosis
- ☐ Frequent Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Oxygen: ☐Daily ☐Nightly

Other:_____

Gastrointestinal
- ☐ C-diff
- ☐ GI Bleed
- ☐ Heartburn/ GERD
- ☐ Hepatitis ☐A ☐B ☐C
- ☐ Irritable Bowel/ IBS
- ☐ Liver Disease - Cirrhosis No
- ☐ Ulcer Disease

Other_____

Genitourinary
- ☐ Kidney Disease - Dialysis? No
- ☐ Kidney Stone
- ☐ Sexually Transmitted Infection
- ☐ Urinary Tract Infection

Last Menstrual period_____
- ☐ Birth control

Other_____

Musculoskeletal
- ☐ Arthritis
- ☐ Back Injury
- ☐ Back Pain
- ☐ Fibromyalgia
- ☐ Osteoporosis

Other_____

Endocrine/ Metabolic
- ☐ Diabetes—Type 1 or 2
- ☐ Thyroid Disease
- ☐ Heat/Cold intolerance

Other _____

Neurological
- ☐ Frequent Headaches
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Seizures

Date of last seizure_____
- ☐ Stroke
- ☐ TIA
- ☐ Guillen Barre
- ☐ Myasthenia Gravis

Psychiatric
- ☐ Addictions
- ☐ Anxiety
- ☐ Depression
- ☐ Mood Swings/ Bipolar
- ☐ Panic Attacks
- ☐ Psychosis/ Schizophrenia
- ☐ PTSD

Hematologic
- ☐ Anemia
- ☐ Bleeding/ Clotting Disorder
- ☐ DVT
- ☐ Sickle Cell Anemia

Blood transfusion ☐Yes ☐No

Other_____

Immunologic
- ☐ AIDS/ HIV
- ☐ Immunosuppression
- ☐ Rheumatic Fever
- ☐ Typhoid Fever

Other_____

Oncological
- ☐ Breast Cancer
- ☐ Colon/ Rectal Cancer
- ☐ Leukemia
- ☐ Lung/ Bronchial Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Urinary/ Bladder Cancer

Other_____

Wound Healing
- ☐ MRSA/ ORSA/ VRE
- ☐ Resistant Organism_____
- ☐ Slow to Heal

Other_____

Implanted Medical devices:
- ☐ Pacemaker
- ☐ AICD (Defibrillator)

Other:_____

_____

Any Other Medical conditions: _____

_____

_____

Family History (check any that apply):

☐ Anemia ☐ Crohns ☐ Ulcerative colitis ☐ Celiac Disease ☐ Colon Cancer ☐ Pancreatitis ☐ Ulcers ☐ Liver Disease
☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Diabetes ☐ Asthma ☐ Kidney Disease ☐ Tuberculosis ☐ Epilepsy
☐ Gastric Cancer ☐ Pancreatic Cancer

Other:_____

Have you ever been diagnosed with Sleep Apnea? _____

If yes do you wear a **CPAP** machine? ☐ Yes ☐ No

SURGICAL PROCEDURES: (check if applicable or write in)

☐ Appendectomy ☐ Tonsillectomy ☐ Hysterectomy ☐ Tubal Ligation ☐ C-Section ☐ Gallbladder ☐ Heart Bypass ☐ Colon Resection

Other surgery: _____

Any surgical procedures that would impair your airway? _____

Has anyone ever told you that you were difficult to intubate (place a breathing tube for surgery)? ☐ **Yes** ☐ **No**

Have you or your family ever had problems with anesthesia? ☐ **Yes** ☐ **No** If Yes, what: _____

Is there anything else we need to know to take better care of you? _____