PENINSULA GASTROINTESTINAL SPECIALISTS, INC

COMPLETED BY ☐ PATIENT ☐ STAFF ☐PROVIDER

Name: _____ Nickname: _____ Referred By: _____

Reason for this visit:_____ Age:_____ Height:_____ Weight:_____

Medical Problems/ Hospitalizations/ Surgeries:

Date

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

Allergies to:

☐ None ☐ Latex ☐ Iodine/Shellfish ☐ Anesthetic ☐ Medications:_____

Medications: (include BCP, calcium, vitamins, aspirin, herbs)

Dosage **Dosage**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Social History:

Occupation:_____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other____

Smoker: ☐ No ☐ Yes, I smoke ____Pack(s) a Day for ____Years.
Coffee: ☐ No ☐ Yes, I drink ____cup(s) a Day for ____Years.

Alcohol: ☐ No ☐Yes, I have ____Drink(s) a Day for ____Years.
Interesting Fact About Yourself? _____

Family:

	Age	Medical Problems	Deceased		M	F	Age	Medical Problems	Deceased
Father	____	_____	☐	Children	☐	☐	____	_____	☐
Mother	____	_____	☐	Children	☐	☐	____	_____	☐
Brother/Sister	____	_____	☐	Children	☐	☐	____	_____	☐
Brother/Sister	____	_____	☐	Other	☐	☐	____	_____	☐
Brother/Sister	____	_____	☐	Other	☐	☐	____	_____	☐

Review of Systems: (Check all that apply)

Last menses:_____ Birth control method:_____

I have: ☐ Pacemaker ☐ Defibrillator ☐ Valve Replacement ☐ Diabetes ☐ Coumadin/Anticoagulation Use

	Past	Current
Constitutional		
Fatigue	☐	☐
Fevers	☐	☐
Weight Loss/Gain	☐	☐
HEENT/Neurology		
Headaches	☐	☐
Seizures/Strokes	☐	☐
Eye Problems	☐	☐
Hearing/Ear Problems	☐	☐
Respiratory		
Shortness of breath	☐	☐
Asthma/Emphysema	☐	☐
Pneumonia/Bronchitis/TB	☐	☐
Sleep Apnea	☐	☐
Cardiology		
Chest Pains	☐	☐
Heart Attack	☐	☐
Rheumatic Fever/Murmur	☐	☐
Antibiotics before dentist	☐	☐
Leg Swelling/Cramping	☐	☐

	Past	Current
Endocrine		
Thyroid Problems	☐	☐
Hematology/Oncology		
Anemia/Transfusions	☐	☐
Bleeding/Clotting Problem	☐	☐
Immune Deficiency	☐	☐
Cancer	☐	☐
Rheum/Derm		
Arthritis/Joint Pains	☐	☐
Immune Disorders	☐	☐
Eczema/Psoriasis	☐	☐
Rashes	☐	☐
Urology		
Prostate Problems	☐	☐
Urinary infections	☐	☐
Kidney Stones	☐	☐
Blood in Urine	☐	☐
Psychology		
Suicide Attempts	☐	☐
Drug/Alcohol Abuse	☐	☐

	Past	Current
Gastroenterology		
Nausea	☐	☐
Vomiting	☐	☐
Heartburn/Regurgitation	☐	☐
Difficulty Swallowing	☐	☐
Ulcers	☐	☐
Hepatitis/Jaundice	☐	☐
Liver Disease	☐	☐
Gallstones	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Bloody/Black Stools	☐	☐
Hemorrhoids	☐	☐
Diverticulosis/Diverticulitis	☐	☐
Abdominal discomfort/pain	☐	☐
Other: _____		
(Office use: 10+ complete)		

Last colonoscopy (date): _____
Any blood tests recently? ☐ Yes ☐ No
Preferred lab (circle one): Quest or Labcorp or Sutter Mills-Peninsula

Date:_____ Patient Signature:_____

Reviewed & Updated:_____