Gastroenterology Associates

Pear M. Enam, MD, FACG • Rashid Hanif, MD, FACG • C.P. Choudari, MD, MRCP

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Consult requested by Dr. _____ for _____

Race

___White/Caucasian ___Black or African American ___Asian ___Hispanic or Latino
___American Indian or Alaska Native ___Native Hawaiian or Other Pacific Islander ___Mixed ___Other
___Unknown ___Patient declines to provide information

Ethnicity

___Hispanic or Latino ___Not Hispanic or Latino ___Patient declines to provide information

Preferred Language

___English ___Spanish ___Other _____

Contact Preference

___Home phone / voice mail ___Work phone / voice mail ___Cell phone / voice mail

Allergies _____No Known Drug Allergies Are you allergic to Latex? Yes / No

I am allergic to: _____

Current Medications

Medication	Dosage	Medication	Dosage
1.		10.	
2.		11.	
3.		12.	
4.		13.	
5.		14.	
6.		15.	
7.		16.	
8.		17.	
9.		18.	

11110 Medical Campus Road • Suite 250 • Hagerstown, MD 21742
Phone 301-733-4404 • Fax 301-733-3984
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Diagnostic Studies / Tests

Tests:	Where / When
Colonoscopy	
Upper Endoscopy (EGD)	
Blood Tests	
CAT Scan	
EKG	
Liver Biopsy	
Stool Occult Blood Test	
Ultrasound	
X-Rays	
Other:	

Previous Procedures - Please indicate any of the following procedures or surgeries you have had: NONE

Appendectomy – When: _____ Heart Bypass – When: _____

Cardiac Stents – When: _____ Pace Maker – When: _____

Defibrillator – When: _____ Stomach/Bowel/Colon – When: _____

Gallbladder Removed: When _____ Uterus/Tubes/ Ovaries – When _____

Gastric Bypass – When: _____

Other procedures / surgeries not listed above: _____

Past or Present Medical Conditions

Please circle the conditions **you** currently experience or have had in the past: NONE

Anemia Angina/Chest Pain Anxiety Arthritis Asthma Cholesterol Problems

Colitis Colon Polyps COPD Crohn's Disease Depression Diabetes

Disease of Pancreas Emphysema Esophagitis Gallbladder Disease GERD Heart Attack

Heart Disease Hemorrhoids Hepatitis High Blood Pressure HIV/AIDS

Irregular Heartbeat Irritable Bowel Syndrome/IBS Jaundice Kidney Disease Liver Disease

Rheumatic Fever Seizure Disorder Sleep Apnea Stroke Thyroid Disease TIA Ulcers

Social History Occupation: _____

Marital Status: Single Married Divorced Separated Widowed Civil Union Unknown Other

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Patient Name: _____

Alcohol ___None

Type _____ Amount _____ Frequency _____

Type _____ Amount _____ Frequency _____

Caffeine ___None

Type _____ Amount _____ Frequency _____

Type _____ Amount _____ Frequency _____

Tobacco

Smoking Status

___Current every day smoker ___Current some day smoker ___Former smoker ___Never smoker

___Smoker, current status unknown ___Unknown if ever smoked

Type _____ Started _____ Quit _____ Quantity _____ Frequency _____

Drug Use ___None

___Used IV drugs in the past ___Used other drugs in the past ___Use recreational drugs now

Family Medical History ___No Knowledge of family history

Do you have a family history of: Celiac Sprue Yes / No Colon Cancer Yes / No

Colon Polyps Yes / No Inflammatory Bowel Disease Yes / No

Liver Disease Yes / No Ulcer problems Yes / No

Diagnosis **FAMILY HISTORY**	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Celiac Disease										
Colon Cancer										
Colon Polyps										
Inflammatory Bowel Disease										
Liver Disease										
Stomach problems / ulcers										
Gallbladder problems										
Pancreas problems										
Heart Disease										

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CARDIOVASCULAR
_____None
Y / N Chest pain
Y / N Palpitations
Y / N Shortness of breath
Y / N Swelling of ankles / feet

CONSTITUTIONAL
_____None
Y / N Fatigue
Y / N Fever
Y / N Weight gain
Y / N Weight loss
Y / N Problems with anesthesia or sedation

EARS/NOSE/THROAT/MOUTH
_____None
Y / N Hearing loss
Y / N Mouth sores
Y / N Ringing in ears

ENDOCRINE
_____None
Y / N Excessive thirst
Y / N Excessive urination
Y / N Cold intolerance
Y / N Heat intolerance

EYES
_____None
Y / N Blurred vision
Y / N Glaucoma

GASTROINTESTINAL
_____None
Y / N Abdominal pain
Y / N Belching
Y / N Black, tarry stools
Y / N Bloating
Y / N Blood in stool
Y / N Change in bowel habits
Y / N Constipation
Y / N Diarrhea
Y / N Difficulty swallowing
Y / N Heartburn
Y / N Nausea
Y / N Poor appetite
Y / N Rectal bleeding
Y / N Regurgitation
Y / N Stomach cramps
Y / N Vomiting
Y / N Anorectal pain

GENITOURINARY
_____None
Y / N Burning with urination
Y / N Blood in urine
Y / N Are you or could you possibly be pregnant?

HEMATOLOGIC/ LYMPHATIC
_____None
Y / N Anemia
Y / N Blood transfusion in the past
Y / N Easy bruising
Y / N Prolonged bleeding

SKIN
_____None
Y / N Itching
Y / N Rashes

MUSCULOSKELETAL
_____None
Y / N Back pain
Y / N Joint pain
Y / N Joint swelling
Y / N Muscle pain
Y / N Muscle weakness

NEUROLOGICAL
_____None
Y / N Frequent headaches
Y / N Numbness or tingling
Y / N Seizures
Y / N Stroke

PSYCHIATRIC
_____None
Y / N Anxiety
Y / N Depression
Y / N Memory loss or confusion

RESPIRATORY
_____None
Y / N Coughing
Y / N Spitting up blood
Y / N Wheezing

Pharmacy

Name: _____ Phone Number: _____

Patient Signature - All information contained on these patient history forms is true and correct to the best of my belief.

Signature: _____ Date: _____