Medical CONSULTANTS
Patient Focused • Quality Oriented • Physician Driven

Muncie	2525 University Ave., Suite 300	Muncie, IN 47303	ph 765•281•2000	fx 765•281•2040
Muncie	800 S. Tillotson Ave.	Muncie, IN 47304	ph 765•281•2000	fx 765•281•2044
Cancer Center	2401 University Ave.	Muncie, IN 47303	ph 765•281•2000	fx 765•281•2114
Marion	1399 N. Baldwin	Marion, IN 46952	ph 765•651•2620	fx 765•651•2630
New Castle	2200 Forest Ridge, Suite 120	New Castle, IN 47362	ph 765•593•2960	fx 765•593•2965
New Castle	1000 North 16th, Suite 240A	New Castle, IN 47362	ph 765•521•1461	

Gastroenterology History Form

Name: ______________________________ Today's Date ______________
Referring Physician: ______________________________ Date of Birth: ______________

Problems/Reason for Office Visit: ______________________________

Medical History: Please check any of the conditions that represent a SIGNIFICANT problem for you

Gastrointestinal	**YES**	**Ears, Nose, Mouth**	**YES**	Sexual problem	
Abdominal pain		Nose bleeds		**Musculoskeletal**	**YES**
Nausea and vomiting		Sinus problems		Broken Bones	
Heartburn or indigestion		Earache		Joint replacement surgery	
Gallbladder problems		Dentures		Gout	
Trouble swallowing		Hearing loss		Arthritis	
Loss of appetite		**Endocrine**	**YES**	Bone or joint pain	
Weight loss		Heat or cold intolerance		**Neurolgic**	**YES**
Diarrhea		Hot flashes		Numbness	
Constipation		Excessive thirst		Headaches	
Rectal pain		Flushing		Stroke	
Hemorrhoids		Changes in body hair		Dizziness	
Blood in stool		**Eyes**	**YES**	Paralysis	
Tarry stools		Glasses/contacts (circle)		**Psychiatric**	**YES**
Liver problems		Glaucoma		Depression	
Hepatitis		Other eye problems		Anxiety	
Cardiovascular	**YES**	**Genitourinary**	**YES**	Other	
Chest pain		Painful urination		**Respiratory**	**YES**
Heart palpitations		Kidney stones		Cough	
Irregular heart beat		Frequency at night		Wheezing	
Heart attack or failure		Urgency		Shortness of Breath	
Heart murmur		Slow or small stream		Asthma	
Heart valve problems		Blood in urine		**Skin**	**YES**
Blood clots		Leaking of urine		Rash, dryness or itching	
Feet or ankle swelling		Poor bladder emptying		Jaundice	
		Menstrual problems		Easy bruising	
		Recurrent bladder infections		Psoriasis or Eczema	
		Abnormal vaginal bleeding		Pigment changes	

Allergies: Latex Y/N Contrast Dye Y/N Medication/Food/Environmental Allergies: ______________________________

____

Medications: Please list all medications. Include over the counter medications (If you need additional space, please bring a list to your appointment.) Include Medication Name, Dosage and Number of times per Day

Name of Medicine	**Dosage**	**How often**	**Name of Medicine**	**Dosage**	**How often**

Past Medical History: Please mark all that apply to yourself.
Please use the key below to fill in the correct family member, if they have had any of the following.

M=Mother **S**=Sister **MGM**=Maternal Grandmother **MGF**=Maternal Grandfather
F=Father **B**=Brother **PGM**=Paternal Grandmother **PGF**=Paternal Grandfather

	You	Family		You	Family
Heart Disease			Ulcerative Colitis		
High Blood Pressure			Ulcer		
High Cholesterol			Bleeding disorder		
Diabetes			Have **you** ever had a blood transfusion		
Thyroid Disease			Kidney Disease		
Colon Cancer			Depression		
Colon Polyps			Psychiatric Disorder		
Crohn's Disease			Seizures		
Liver disease			Lung Disease		
Pancreatic Disease			TB		

Last Tetanus Shot __________________ Pneumonia Vaccine _____________________ Flu Shot ____________________
Hepatitis A Vaccine ___________________ Hepatitis B Vaccine ____________________ TB Skin Test _______________

Recent Colonoscopy: Y/N When________ Where_________ **Endoscopy (EGD) Y/N** When_______ Where__________

Surgeries and Procedures: Please list any/all **surgeries.**

Family History:

Relative	Age	Living	Deceased	Disease or Cause of Death
Father				
Mother				
Siblings				

Social History: Please circle answers below.
Do you drink alcohol? Y/N If yes, indicate on average how much and circle day, week, month, or year:
#_______Beer per: Day Week Month Year
#_______Glasses of wine per: Day Week Month Year
#_______Hard Liquor Day Week Month Year
Did you use to drink heavily? Y/N How long did you drink heavily? ____________________
When did you quit or cut down on drinking? _____________ Do people get annoyed by you drinking? Y/N
Do you feel guilty about drinking? Y/N Do you drink alcohol in the morning? Y/N
Do you use tobacco? Y/N Cigarettes___ Cigars___ Chewing Tobacco___
If yes, How much per day?____ Packs____ Singles ____ Cans____
# of years? ____ Previous treatment? Y/N What type of treatment? _________ Ready to Quit Y/N
Do you or have you ever-used street drugs? Y/N What:_________________ Do you have Tattoos? Y/N