Gastroenterology Associates of S.W. Florida, P.A.

NEW PATIENT / ANNUAL HEALTH UPDATE

Patient Name: _____ **Date of Birth:**_____
Date: _____

Allergies: (Drug/Food/Environmental)
☐ Penicillin ☐ Sulfas ☐ Latex ☐ Aspirin ☐ Codeine ☐Other: _____

PLEASE SELECT THE REASON YOU ARE SEEING THE PHYSICIAN TODAY:

☐ Screening	☐ Due for Colonoscopy	☐ Due for EGD	☐ Hospital Follow-up
☐ Abdominal Pain	☐ Diarrhea	☐ Constipation	☐ Rectal Bleeding
☐ Bloody/Tarry Stools	☐ Crohn's	☐ Colitis	☐ Irritable Bowel Disease (IBD)
☐ Cirrhosis	☐ Hepatitis	☐ Swallowing Difficulty	☐ Reflux
☐ Nausea	☐ Vomiting	☐ Loss of Appetite	☐ Weight Loss/Weight Gain

☐ Other (please describe): _____

PLEASE LIST ALL MEDICAL CONDITIONS (Check all that apply):

☐ Diabetes	☐ High Blood Pressure	☐ Chest Pain	☐ Congestive Heart Failure
☐ Heart Disease	☐ Vascular Disease	☐ Arrhythmia	☐ Atrial Fibrillation (a-fib)
☐ Heart Attack	☐ Stroke	☐ Asthma	☐ Sleep Apnea
☐ COPD	☐ Pneumonia	☐ Seizures	☐ Paralysis
☐ Cystic Fibrosis	☐ Kidney Disease	☐ End Stage Renal Disease	☐ Dialysis
☐ HIV/AIDS	☐ Immune Deficiency	☐ Cirrhosis	☐ Hepatitis
☐ Intestinal Obstruction	☐ IBD/Crohn's/Colitis	☐ Chronic Pancreatitis	☐ Hernia: _____
☐ Transplant: _____	☐ Amputation: _____	☐ Broken Bones/Fractures: _____	
☐ Cancer:_____		☐ Other: _____	

Please list all surgeries you have had:

☐ Appendectomy	☐ Tonsillectomy	☐ Gallbladder removal	☐ Colectomy
☐ Hemorrhoidectomy	☐ Hernia Repair	☐ Coronary Artery Bypass	☐ Pacemaker
☐ Stent Placement	☐ Cataract Surgery	☐ Back Surgery	☐ Prostatectomy
☐ Cesarean Section	☐ Mastectomy	☐ Hysterectomy	☐ Skin Graft

☐ Repair of Broken Bone/Fracture: _____
☐ Other (please describe): _____

Family Medical History (Check all that apply):

☐ Colon Polyps	☐ Colon Cancer	☐ Lynch Syndrome	☐ Pancreatic Cancer
☐ Breast Cancer	☐ Liver Cancer	☐ Gastric/Esophageal Cancer	☐ Cancer (specify): _____
☐ Colitis	☐ Barrett's Esophagus		

Relationship to Patient and Age of Diagnosis: _____

Medical Questions:

☐Yes ☐ No Do you have heartburn requiring over-the-counter medicine more than twice a week?
☐Yes ☐ No Have you had a cough lately, for more than two weeks?
☐Yes ☐ No Have you had a fever lately, for more than one week?
☐Yes ☐ No Are you more short of breath without activity than you were two years ago?
☐Yes ☐ No Have you had chest pain or heaviness within the last three months? Has this been evaluated by a doctor? ____
☐Yes ☐ No Have you been having abdominal pain recently?
☐Yes ☐ No Do you take blood thinners, i.e., Coumadin, Aspirin, etc.?
☐Yes ☐ No Do you have allergies bad enough to take prescription meds?
☐Yes ☐ No Do you smoke? If yes, how many packs a day?_____
☐Yes ☐ No Do you drink alcohol? If yes, how many glasses of wine, beer, or ounces of liquor per day?_____
☐Yes ☐ No Do you drive?
☐Yes ☐ No Do you have a power of attorney (POA)?
☐Yes ☐ No Do you have a legal guardian?
☐Yes ☐ No **For females only**: Is there a possibility that you are pregnant? Date of Last Menstrual Period: _____

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