Please fill out completely and bring to your first visit.

Tri Valley Gastroenterology

Name: _____ Who may we thank for referring you? _____

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

Medical Problems-Hospitalizations-Surgeries: **Date** **Date**

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

Allergies: ☐ None, Allergies to: ☐ Latex ☐ Iodine/Shellfish ☐ Anesthetic ☐ Medications:_____

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

_____ _____
_____ _____
_____ _____
_____ _____

Social History: Occupation:_____ ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other_____

Smoker: ☐ NO ☐ YES, I smoke approximately_____Pack(s) a Day for _____Years. Alcohol: I have approximately _____Drink(s) a Day.

Family:

	Age	Medical Problems	Deceased		M	F	Age	Medical Problems	Deceased
Father	___	_____	☐	Children	☐	☐	___	_____	☐
Mother	___	_____	☐	Children	☐	☐	___	_____	☐
Brothers/Sisters	___	_____	☐	Children	☐	☐	___	_____	☐
Brothers/Sisters	___	_____	☐	Children	☐	☐	___	_____	☐
Brothers/Sisters	___	_____	☐	Children	☐	☐	___	_____	☐

Review of Systems: (Please check all that apply) Last Menses:_____Birth Control Method:_____

I have: ☐ Pacemaker ☐ Mastectomy ☐ Dentures ☐ Eyeglasses ☐ Hearing Aid ☐ _____
☐ Diabetes ☐ High blood pressure ☐ Heart Failure ☐ Organ Transplant ☐ Valve Replacement ☐ Coumadin/Warfarin use

I have:	Past	Current
Constitutional		
Fevers	☐	☐
Weight Changes	☐	☐
Fatigue/Weakness	☐	☐
HEENT/Neurology		
Headaches	☐	☐
Seizure/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 or Cramps	☐	☐

	Past	Current
Endocrine		
Thyroid Problems	☐	☐
Hematology/Oncology		
Anemia/Transfusions	☐	☐
Bleeding/Clotting Disorders	☐	☐
Immune Deficiency	☐	☐
Cancer	☐	☐
Rheumatology		
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 Dis.	☐	☐
Gallstones	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Bloody/Black Stools	☐	☐
Diverticulosis or Diverticulitis	☐	☐
Abdominal discomfort/pain	☐	☐

DATE: _____ PATIENT SIGNATURE: _____

DO NOT WRITE BELOW THIS LINE

HEALTH QUESTIONNAIRE