NAME:_____ DOB:_____

ADVANCED DIGESTIVE CARE, A Division of Gastro Florida

Gastrointestinal / Esophageal Disorders and Endoscopic Ultrasonography

We **WELCOME** you to our office and will try our utmost to provide the best possible care. In order for us to avoid repetitive questions at every visit, we would like you to take a few moments and fill your medical history as accurately as possible in the following pages.

Today's Date:_____

NAME: _____

DATE OF BIRTH_____AGE:_____ SEX_____ Married / Single / Divorced/Other

ALLERGIES:_____

_____

CHIEF COMPLAINT/(WHY ARE YOU HERE):

PAST/CURRENT ILLNESSES YOU ARE BEING TREATED FOR:

PAST SURGICAL HISTORY:

MEDICATIONS and Doses (**Including supplements/vitamins**):

NAME:_____ DOB:_____

SOCIAL HISTORY:

YOUR OCCUPATION:_____SPOUSE'S OCCUPATION_____

Do You Have Kids: Yes/No How Many: Boys_____ Girls_____

Do You Smoke: Yes / No/ Used To _____Packs/ day. For: _____Years

Do You Drink Alcohol: Yes / No / Used To.

If Yes: Daily / Alternate Day / Weekends / Occasionally.

Estimated alcohol consumption: BEER_____Wine____Hard Liquor_____Per Day/Week/Month.

Were you a heavy drinker in the past_____ If Yes how many years_____

How Many Cups of Coffee Do You Drink Daily_____

Number and type of Carbonated Drinks you Consume Daily_____

FAMILY HISTORY:

Any Illnesses That Run In the Family: _____

(Please specify cancer, heart disease, high blood pressure, strokes, TB, etc.)

RELATION	ILLNESS AGE	IF DIED, CAUSE	Other Details
Mother			
Father			
# of Brothers			
# of Sisters:			
Children:			
Paternal/Maternal Grandparents			

PREVENTIVE HEALTH CARE: (Indicate the Last Time the following were performed if ever):

Stool for Blood Testing: _____ Flexible Sigmoidoscopy:_____

Colonoscopy: _____ Yearly Physical Exam:_____

Women: Pap Smear_____ / Mammogram_____/Monthly Self Exam_____

Men: Prostate Exam_____PSA Test_____

NAME:_____ DOB:_____

REVIEW OF SYSTEMS: (**Circle All Positives for the last 3 months**)

GENERAL:

Weight Loss/Gain. _____ Pounds. Fatigue, Fever Chills, Night Sweats, Diabetes, Thirst, Frequent Urination

HEENT:

Frequent Headaches, Dizziness, Wear Glasses, Cataracts, Eye Pain, Visual Problems, Hearing Difficulty, Ringing in Ears, Chronic Runny / Stuffy Nose, Hoarseness.

CARDIOVASCULAR:

Heart Attacks, Chest Pain, Palpitations, Irregular Heartbeat, Swelling in feet, Blood Clots in legs

RESPIRATORY:

Shortness of Breath: At Rest _____With exertion _____, while laying flat _____,
Cough, (if yes) Dry / With Sputum. Color of Phlegm: White / Brown / Green / Red. Wheezing, Asthma, Emphysema, Sleep Apnea.

GASTROINTESTINAL:

APPETITE: Good/ OK / Poor. Swallowing Difficulty, Nausea, Vomiting, Diarrhea, Constipation, Change in Bowel Habit
Usual Bowel Habits (How Often) _____
Heartburn, Reflux, Abdominal Pain, Peptic Ulcer, Red/Blood in Stool, Black Stool, Hemorrhoids, Anemia, Blood Transfusion, Jaundice/Yellow color skin, Hepatitis,
Abdominal Surgery, Colon Polyps, Family History of Colon Cancer , Bruise Easily
Gall Bladder Disease.

SKIN / MUSCULOSKELETAL: Bone/Joint Pain, Stiffness, Red / Swollen Joints

GENITOURINARY: Painful / frequent urination, Urine Infection, Blood in Urine,
Are You Pregnant _____, Last Menstrual Cycle _____

NEURO/ ENDOCRINE: Strokes, Numb/Weak limb, Slurry speech, Have Thyroid Problems

NAME:_____ DOB:_____

This space is for Physician Use Only:

Physical Exam Findings: Height: Weight: Pulse: BP: Resp:

System Check if Normal
HEENT:
Neck:
Lungs:
Heart:
GI/Abdomen: **Liver Span:** **Tenderness:**
Ascites: **Rectal:**
Exam Check if Normal
Ms/Skeletal:
Gross Neurol:
Dermatological:
Endocrine:
Genitourinary:
CC:

HPI:

IMPRESSION:

RECOMMENDATIONS:

History Reviewed and confirmed, Exam Performed:**Umesh Choudhry,M.D./Gourishankar Degala, M.D.**