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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

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

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

<p><u>CARDIOVASCULAR</u> _____ None Y / N Chest pain Y / N Palpitations Y / N Shortness of breath Y / N Swelling of ankles / feet</p> <p><u>CONSTITUTIONAL</u> _____ None Y / N Fatigue Y / N Fever Y / N Weight gain Y / N Weight loss Y / N Problems with anesthesia or sedation</p> <p><u>EARS/NOSE/THROAT/MOUTH</u> _____ None Y / N Hearing loss Y / N Mouth sores Y / N Ringing in ears</p> <p><u>ENDOCRINE</u> _____ None Y / N Excessive thirst Y / N Excessive urination Y / N Cold intolerance Y / N Heat intolerance</p> <p><u>EYES</u> _____ None Y / N Blurred vision Y / N Glaucoma</p>	<p><u>GASTROINTESTINAL</u> _____ 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</p> <p><u>GENITOURINARY</u> _____ None Y / N Burning with urination Y / N Blood in urine Y / N Are you or could you possibly be pregnant?</p> <p><u>HEMATOLOGIC/ LYMPHATIC</u> _____ None Y / N Anemia Y / N Blood transfusion in the past Y / N Easy bruising Y / N Prolonged bleeding</p>	<p><u>SKIN</u> _____ None Y / N Itching Y / N Rashes</p> <p><u>MUSCULOSKELETAL</u> _____ None Y / N Back pain Y / N Joint pain Y / N Joint swelling Y / N Muscle pain Y / N Muscle weakness</p> <p><u>NEUROLOGICAL</u> _____ None Y / N Frequent headaches Y / N Numbness or tingling Y / N Seizures Y / N Stroke</p> <p><u>PSYCHIATRIC</u> _____ None Y / N Anxiety Y / N Depression Y / N Memory loss or confusion</p> <p><u>RESPIRATORY</u> _____ None Y / N Coughing Y / N Spitting up blood Y / N Wheezing</p>
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Pharmacy

Name: _____ Phone Number: _____

If necessary, your medical information can be released to someone other than yourself. Please list names of authorized people:

Spouse: _____ Yes _____ No

Parent: _____ Yes _____ No

Other Names: (Please list relationship such as daughter, son, boyfriend, girlfriend, fiancé, sister, etc.)

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

Signature: _____ Date: _____