Gastroenterology Associates of Gainesville, P.C.

Medical Information Sheet

Patient Name: ___________________________ DOB: _____________ MRN: ______________ Date: _______________

Primary Care Physician: ___________________________________ Referring Physician: ___________________________________

Email Address: ____ **Reason for visit:** ____

Where is the problem located: _________________________________ **For how long:** _____________________________________

Does anything make it better: ______________________________________ **Worse:** ____

Have you had past surgeries? What kind: ____**When:** ___________________________

Are you married? □ Yes □ No Occupations: ______________________________ Number of children? _____________

Have you had a flu shot in the past year: □ Yes ___ /_____ (*mo / year*) □**No** **Have you had a Pneumonia shot:** □ Yes _________ (*year*) □ No

Have you **ever** smoked? □Yes □No

Have you **ever** consumed alcohol? □Yes □No

Have you **ever** used injection/recreational drugs? □Yes □No

Do you **currently** smoke? □Yes □No

Do you **currently** drink alcohol? □Yes □No

Do you **currently** use drugs? □Yes □No

Does your family have history of the following cancers, if so who: ____

What type: □ Colon □ Stomach □ Liver □ Pancreas □ Breast □ Ovarian □ Uterine □ Brain

Are you currently experiencing any of the following symptoms?

Headaches	□ Yes	□ No	Dizziness	□ Yes	□ No	Numbness/Tingling	□ Yes	□ No
Fever/chills	□ Yes	□ No	Chest Pain	□ Yes	□ No	Swollen Lymph Nodes	□ Yes	□ No
Blurred/Double Vision	□ Yes	□ No	Shortness of Breath	□ Yes	□ No	Swollen Glands	□ Yes	□ No
Bleeding Gums	□ Yes	□ No	Sore Throat	□ Yes	□ No	Difficulty/bloody Urine	□ Yes	□ No
Abdominal Pain	□ Yes	□ No	Change in Appetite	□ Yes	□ No	Nausea	□ Yes	□ No
Reflux/Heart Burn	□ Yes	□ No	Excessive Gas	□ Yes	□ No	Vomiting	□ Yes	□ No
Difficulty Swallowing	□ Yes	□ No	Loose Stools	□ Yes	□ No	Bloating	□ Yes	□ No
Blood on Toilet Paper	□ Yes	□ No	Blood in Stool	□ Yes	□ No	Hard Stools	□ Yes	□ No

Change in Weight: □ Yes □ No If yes, please Explain: ____

Change in Color/Shape/Consistency of Stool: □ Yes □ No ____

Do you have a history of or have you ever been treated for any of the following?

High Blood Pressure	□ Yes	□ No	Chronic Back Pain	□ Yes	□ No	Seizures	□ Yes	□ No
Diabetes	□ Yes	□ No	Arthritis	□ Yes	□ No	Glaucoma	□ Yes	□ No
High Cholesterol	□ Yes	□ No	Stroke	□ Yes	□ No	Cataract	□ Yes	□ No
Sleep Apnea	□ Yes	□ No	Depression	□ Yes	□ No	Thyroid Disorder	□ Yes	□ No
COPD/Emphysema/Bronchitis	□ Yes	□ No	Hepatitis	□ Yes	□ No	Blood Clots(lungs/legs)	□ Yes	□ No
Heart Disease	□ Yes	□ No	Jaundice	□ Yes	□ No	Cancer	□ Yes	□ No
Fibromyalgia	□ Yes	□ No	**Other Disorders**	____________________				
Bleeding Disorder	□ Yes	□ No	Not Mentioned:	____________________				

<u>Female Patients Only:</u> Regular menstrual periods□ Yes □ No History of frequent /heavy bleeding? □ Yes □ No

Type of contraception: ________________

Patient's Signature: ____ Date: ________________