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 ___ /_____ □**No** (*mo / year*) **Have you had a Pneumonia shot:** □ Yes _____ □ No (*year*)

Have you **ever** smoked? □Yes □No Do you **currently** smoke? □Yes □No

Have you **ever** consumed alcohol? □Yes □No Do you **currently** drink alcohol? □Yes □No

Have you **ever** used injection/recreational drugs? □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
Congestive Heart Failure (CHF)	□ Yes	□ No	Jaundice	□ Yes	□ No	Cancer	□ Yes	□ No
Fibromyalgia	□ Yes	□ No	**Other Disorders**					
Bleeding Disorder	□ Yes	□ No	Any heart condition					

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

Type of contraception: _____

Patient's Signature: _____ Date: _____