GRIFFIN FACULTY PHYSICIANS

Gastroenterology

Patient Name: _____ DOB: _____

Referring MD: _____ Referring phone: _____

Primary Care Physician: _____ Phone:_____

Have you recently had a physical exam? □Yes _____ □ No

Have you recently had lab work? □Yes _____ □ No

First colonoscopy: ☐ YES ☐ NO If no, Date : _____ MD:_____

If NO, Have you ever had polyps or colon cancer? □Yes (**TYPE OF POLYPS**- _____) □ No

If NO, Has it been 10 years since your last colonoscopy? □Yes □ No

Have you ever had an organ transplant? □Yes _____ □No

Cardiovascular:

Are you on any blood thinners? □Yes _____ □ No

Do you have congestive heart failure? □Yes _____ □ No

Do you have heart disease? □Yes _____ □ No

Please check each item as they relate to your health

_____ Chest Pain _____ Irregular Heart _____ Shortness of breath

_____ High Blood Pressure

_____Heart Bypass Surgery If yes, Date: _____

_____Valve Surgery If yes, Date: _____

_____ Heart Attack If yes, Date: _____

_____Stents If yes, Date: _____

Do you have a Defibrillator and/or Pacemaker? □Yes □ No

Cardiologist: _____ Phone: _____

Genitourinary: Please check each item as they relate to your health

_____ Kidney disease/failure Are you a dialysis patient? □Yes □ No

_____Diabetes If yes, _____Insulin _____oral meds:_____

Nephrologist: _____ Phone: _____

Neurologic: Please check each item as they relate to your health

_____Stroke/TIA If yes, Date: _____

_____ Seizures If yes, Last Date:_____

General: Please check each item as they relate to your health

_____ Dizziness _____ Fatigue _____Fever _____Wheelchair Bound

_____ Unexplained Weight Loss _____ lbs_____ Unexplained Weight Gain _____ lbs

Gastroenterology: Please check each item as they relate to your health

_____ Abdominal Pain If yes, where_____

_____ Daily bowel movement

_____ Constipation _____ Diarrhea _____ Nausea _____Heartburn/Reflux

_____Difficulty/Painful Swallowing _____Vomiting

_____Rectal Bleeding/Blood in Stool _____ Ulcerative Colitis ___ ____Crohn's Disease

_____Liver Disease _____

_____Intestinal Surgery in the last 6 months? _____

_____ History of Anemia _____Bruise easily

Any relatives with colon cancer AND/OR polyps? Who and what age were they?

_____

Psychological: Please check each item as they relate to your health

_____Depression _____Anxiety/Panic Attacks _____ Dementia/Memory Loss

_____Other _____

Respiratory: Please check each item as they relate to your health

_____Sleep apnea _____ Shortness of Breath _____ Asthma (recent treatment)

_____ COPD/Emphysema/Chronic Bronchitis _____ On Oxygen □Yes □ No

Hospitalized within the last month: □Yes □ No

Have you ever had problems with anesthesia? □Yes □ No

Previous Surgeries and Dates:

1. _____

2._____

3. _____

4._____

Allergies

NAME	**REACTION**
1._____	_____
2._____	_____
3._____	_____

Medications (prescription or over the counter including vitamins, etc.):

NAME	DOSAGE	HOW OFTEN
1.		
2.		
3.		
4.		
5.		
6.		

ADDITIONAL INFORMATION THE PHYSICIAN SHOULD BE AWARE OF :