MAIN GASTROENTEROLOGY, P.C.

HEALTH INFORMATION

Patients Name:_____Date of Birth:_____

PERSONAL HISTORY: If you have any of these symptoms please circle.

General: loss or gain of weight, weakness, fever, chills, sweats, night sweats, poor appetite.

Oral: disturbance of taste, difficulty in swallowing, hoarseness.

Neck: pain, stiffness, masses, thyroid enlargement.

Cardio respiratory: chest pain, cough, sputum, coughing up blood, wheezing, shortness of breath, leg edema.

Gastrointestinal: abdominal pain, nausea, vomiting, rectal bleeding, hemorrhoids, constipation, diarrhea.

Central Nervous System: loss of consciousness, stroke, change in sleep patterns, tremors, paralysis, loss of sensation.

Blood: anemia, blood transfusions, prolonged or unusual bleeding, bruise easily.

Endocrine: change in speaking or singing voice, increased thirst or volume of urination, change in sex drive or potency.

Are you allergic to any drugs or IV dyes? **yes/no**

Do you use tobacco products? If so which ones?_____

Do you drink alcohol? **yes/no**. How much?_____

Women: Are you pregnant? **yes/no**. What trimester?_____

OVER →

Please list all Medical Illnesses:

_____

_____

_____

Please list all past surgeries and dates:

_____

_____

_____

Are you presently taking any medications? **yes/no**

If you are taking medications please list all and doses and how taken:

_____

_____

_____

_____

_____

Thank you.