

Digestive Health *Specialists*

ESTABLISHED PATIENT INFORMATION UPDATE

Please bring this form with you for your appointment on: Date _____ Time _____

Name: _____	Date of Birth: _____
Address: _____	Social Security #: _____
Marital Status: _____	Primary Care Physician/Practitioner: _____
Reason for visit: _____	Occupation: _____

Have you had any:

COMMENT

<input type="checkbox"/> Surgeries _____	<input type="checkbox"/> Hospitalizations _____
<input type="checkbox"/> Illnesses _____	_____
_____	_____

Yes No

Alcohol Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what kind _____ How many drinks per week? _____ When was your last drink? _____		
Have you ever felt the need to cut down on drinking?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever felt annoyed by criticism of your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had guilty feelings about your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken a drink in the morning to get rid of a hangover or steady your nerves?	<input type="checkbox"/>	<input type="checkbox"/>

Tobacco Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
Cigarettes: Packs per day _____ Chew: #/day _____ Pipe: #/day _____ Cigars: #/day _____		
Number of years _____ Year quit _____		

CHANGES IN HEALTH IN THE LAST YEAR (PLEASE CHECK ONLY THOSE ITEMS WHICH APPLY):

GENERAL	<input type="checkbox"/> Bronchitis/Pneumonia	<input type="checkbox"/> Constipation	MUSCULOSKELETAL
<input type="checkbox"/> Weight Loss lbs.	<input type="checkbox"/> Chest Pain or Pressure	<input type="checkbox"/> Cramps	<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Weight gain lbs.	<input type="checkbox"/> Rapid/Irregular Heartbeat	<input type="checkbox"/> Bloating/Gas	<input type="checkbox"/> Pain/Stiffness in Neck or Back
<input type="checkbox"/> Fevers	<input type="checkbox"/> SOB/Abnormal Swelling Legs/Feet	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Pain/Stiffness/Swelling in Joints
<input type="checkbox"/> Chills or Sweats	PULMONARY	<input type="checkbox"/> Decreased Appetite	NEURO/PSYCH
<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Mucus in Stool	<input type="checkbox"/> Dizziness/Equilibrium Problems
SKIN	<input type="checkbox"/> Coughing Up Sputum/Blood	<input type="checkbox"/> Black Stools	<input type="checkbox"/> Headaches or Migraines
<input type="checkbox"/> Allergic Reactions	<input type="checkbox"/> Exposed to Tuberculosis	<input type="checkbox"/> Milk or Dairy Intolerance	<input type="checkbox"/> Numbness or Tingling
<input type="checkbox"/> Breast Tenderness/Mass or Biopsy	<input type="checkbox"/> Abnormal Swelling Legs/Feet	ENDOCRINE	<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Skin Rashes	<input type="checkbox"/> Wheezing/Asthma	<input type="checkbox"/> Excessive Urination	<input type="checkbox"/> Lost Consciousness
<input type="checkbox"/> Abnormally Pigmented Areas	GI	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Seizures
HEENT	<input type="checkbox"/> Difficulty in Swallowing	<input type="checkbox"/> Intolerance to Heat	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Loss of Hearing	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Intolerance to Cold	<input type="checkbox"/> Depression
<input type="checkbox"/> Double/Blurred Vision	<input type="checkbox"/> Abdominal Pain	HEME/LYMPH	<input type="checkbox"/> Panic Attack
<input type="checkbox"/> Sinus Problems/Nosebleeds	<input type="checkbox"/> Vomiting or Nausea	<input type="checkbox"/> Anemia	<input type="checkbox"/> Retirement/Change of Job
<input type="checkbox"/> Hoarseness/Sore Throat	<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Easy/Increased Bruising	<input type="checkbox"/> Death of a Loved One
<input type="checkbox"/> Cataracts or Glaucoma	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Enlarged/Swollen Glands	
<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Rectal Pain	<input type="checkbox"/> Nosebleeds	
CARDIOPULMONARY	<input type="checkbox"/> Leakage of Stool	<input type="checkbox"/> Abnormal/Increased Bleeding	

Thank you for your time. This information will assist us to help you. Remember to bring this form to your appointment. Please feel free to call if you have questions.

Patient Signature: _____ Date: _____

Reviewing Physician's Signature: _____ Date: _____