PATIENT HISTORY

R.E. Flanigan, M.D. R.J. Pagano, M.D.

Name	_____	Visit Date:	/ /
Address	_____	D.O.B / /	Age ____
	_____	Referring M.D.	_____
Phone	( ) - _____	Hospital / Office	St. Clair ☐ UPMC ☐
Occupation:		Email address:	

Reason for today's procedure/visit: _____

G.I. SYMPTOMS - *Please check symptoms you have experienced recently.*

Lack of Appetite ☐	Trouble Swallowing ☐	Black Stool ☐	Weight Loss ☐
Heartburn ☐	Food sticking in chest ☐	Light gray stool ☐	Weight Gain ☐
Indigestion ☐	Mild abdominal pain ☐	Red blood on tissue ☐	Diarrhea ☐
Food Intolerance ☐	Severe abdominal pain ☐	Red blood in stool ☐	Mucous in stools ☐
Nausea ☐	Excessive Belching ☐	Dark blood in stool ☐	Constipation ☐
Vomiting ☐	Fullness after meals ☐	Dark urine ☐	Painful bowel movements ☐
Vomiting Blood ☐	Burning in pit of stomach ☐	Yellow skin or eyes ☐	Change in caliber of stool ☐

Please explain further any positive responses or list any other GI symptoms:

_____

_____

Medicines/Prescriptions

	Name	***Dose***	***Frequency***	***Last dose***
1				
2				
3				
4				
5				
6				

Drug Allergy Yes ☐ No ☐

If yes, name Reaction

1. _____ _____
2. _____ _____
3. _____ _____

Latex Allergy Yes ☐ No ☐

Iodine Allergy Yes ☐ No ☐

Food Allergy Yes ☐ No ☐

Foods:

Herbs (please list):_____

Vitamins (please list): _____

Please check any of the following medicines you have taken in the past year

Prednisone ☐	Parnate (Tranylcypromine) ☐	Eldepryl (Selegiline) ☐	Azilect (rasagiline) ☐
Iron ☐	Nardil (Phenelzine) ☐	Marplan (Isocarboxazid) ☐	Accutane (isotretinoin) ☐

REVIEW OF SYSTEMS

Symptoms you have had recently... (please check any that apply)

1) Constitutional:	Recent weight change ☐	Fever ☐	Fatigue ☐	Night Sweats ☐
2) Eyes:	Blurred Vision ☐	Glaucoma ☐	Cataracts ☐	Inflammation ☐
3) ENT:	Hearing loss ☐	Ringing in ears ☐	Mouth sores ☐	Nose bleed ☐
4) Cardiovascular:	Chest pain ☐	Fainting ☐	Swelling of ankles ☐	Rapid/Irreg Heart ☐
5) Respiratory:	Chronic cough ☐	Spitting up blood ☐	Wheezing ☐	Shortness of Breath ☐
6) Genitourinary:	Burning/foul urine ☐	Blood in urine ☐	Urgency ☐	Hesitancy ☐
7) Musculoskeletal:	Joint pain or swelling ☐	Back pain ☐	Muscle pain ☐	Leg Cramps ☐
8) Skin:	Rash ☐	Itching ☐	Hives ☐	Hair Loss/Nail ☐
9) Neurological:	Headaches ☐	Seizures ☐	Numbness ☐	Arm/Leg Weakness ☐
10) Psychiatric:	Memory loss or confusion ☐	Depression ☐	Anxiety ☐	Sleeping Difficulties ☐
11) Endocrine:	Heat or cold intolerance ☐	Excessive thirst ☐	Excessive urination ☐	Impotence ☐
12) Hematological:	Bleeding or bruising tendency ☐	Anemia ☐	Past Transfusion ☐	Swollen lymph node(s) ☐

Please list any other non GI symptoms: _____

(PLEASE CONTINUE ON REVERSE)

Patient Name: _____

PAST MEDICAL HISTORY

Have you ever had... (please check any that apply)

Anemia ☐	Asthma ☐	Cancer/Tumor ☐	Osteopenia ☐
Blood Clotting Problem ☐	COPD/Emphysema ☐	Frequent Alcohol Ingestion ☐	Osteoporosis ☐
Blood transfusions ☐	Glaucoma ☐	Stomach/Duoden. Ulcer ☐	Degenerative arthritis ☐
Diabetes ☐	Hypothyroidism ☐	Hiatal Hernia ☐	Dexa scan ☐
Chronic Kidney Disease ☐	Hyperthyroidism ☐	Ulcerative Colitis ☐	CT Abdomen ☐
Dialysis ☐	Anginal Chest Pain ☐	Crohn's Disease ☐	MRI Abdomen ☐
Kidney Stones ☐	Other chest pain ☐	Diverticulitis ☐	Ultrasound abdomen/GB ☐
Bladder trouble ☐	Heart attack ☐	Spastic/irritable bowel ☐	CT Colonography ☐
Sleep Apnea ☐	Treadmill/Stress Test ☐	Milk intolerance ☐	Barium Enema ☐
Depression ☐	Heart Cath ☐	Hepatitis ☐	Capsule Endoscopy ☐
Psychosis ☐	Heart Stent(s) ☐	Pancreatitis ☐	Upper G.I./SB ☐
Severe anxiety ☐	Irregular Heart Beat ☐	Liver Disease ☐	Colonoscopy ☐
Seizures ☐	Heart Murmur ☐	Gall bladder disease ☐	Gastroscopy ☐
Fainting Spells ☐	High blood pressure ☐	Hemorrhoids ☐	Sigmoidoscopy / Procto ☐

Please use this space to explain any positive responses and list dates.

_____

_____

_____

PREVIOUS SURGERIES - *Please check and list <u>date</u> next to any that may apply.*

Gall Bladder - Conventional ☐	Hiatal Hernia Repair ☐	Vascular stent(s) ☐
Gall Bladder - Laparoscopic ☐	Inguinal Hernia Repair ☐	Hysterectomy (Ovaries Intact) ☐
Stomach/Ulcer Surgery ☐	Heart-valve replacement ☐	Hysterectomy (Ovaries Removed) ☐
Laparotomy/Lysis Adhesions ☐	Coronary Artery Bypass ☐	Pelvic Laparoscopy ☐
Colon Resection ☐	Pacemaker ☐	Appendix ☐
Joint/Knee Replacement ☐	Heart Defibrillator ☐	Gastric bypass/wt. loss surg. ☐
Hip Replacement ☐	Coronary stent(s) ☐	Other: _____

OTHER HOSPITALIZATIONS - *Please list in order from most recent.*

YEAR	*ILLNESS*	*HOSPITAL*
1.		
2.		
3.		
4.		

FAMILY HISTORY - *Please check any conditions that any first or second degree relatives have had.*

Colon cancer ☐	Celiac Sprue ☐	Alcoholism ☐	Diabetes ☐
Colon polyps ☐	Stomach/Duodenal ulcers ☐	Hepatitis ☐	Stroke ☐
Ulcerative Colitis ☐	Other cancer (list): ☐	Cirrhosis ☐	High blood press ☐
Crohn's Disease ☐	_____		

SOCIAL HISTORY

Do you Drink? Yes ☐ No ☐ Wine ☐ Beer ☐ Liquor ☐

Average alcohol intake: ____days/wk ____glasses per day ☐ less than weekly alcohol

Do you Smoke? Yes ☐ No ☐ ____ Packs per day **X** ____ Years (Former Smoker ☐)

Daily Beverages: Coffee Reg. ☐ Decaf. ☐ Cola Reg. ☐ Cola Diet ☐ Tea ☐ Serv./Day ____

Sexually active? Yes ☐ No ☐

DIET:

Do you ever feel that you lose control over the way you eat? Yes ☐ No ☐

Are you presently on a diet or planning to start one soon? Yes ☐ No ☐

Are you dissatisfied with you weight/shape? Yes ☐ No ☐

WOMEN ONLY:

Are you: Pre ☐ Post ☐ Menopausal

Chance of current pregnancy? Yes ☐ No ☐

History of heavy menses/Bleeding? Yes ☐ No ☐

History of Endometriosis? Yes ☐ No ☐

Are present G.I. symptoms related to menses cycle? Yes ☐ No ☐

Date of last period: _____

Last Visit to gynecologist (date) _____

Last pap smear _____

_____ _____

Patient Signature Date