Westside Gastroenterology

Name:..... **Date of Birth:**.....

1. Chief complaint and brief description:.....

.....

.....

.....

How long have you had this problem? .....

2. Have you been seen by any other gastroenterologists for this problem or any other problem?

.....

If yes, have you had:

STUDY	LOCATION	YEAR
Upper Endoscopy		
Colonoscopy		
CT Scan or Ultrasound		

3. Please check YES or NO if you have any history of the following:

CONDITION	YES	NO	CONDITION	YES	NO
Abnormal Liver Tests			Gallbladder Problems		
Anemia			Hepatitis B or C		
Anxiety			Hypertension		
Arthritis			Irregular Heart Rhythm		
Blood Clotting Problems			Kidney Stones		
Cancer			Liver Disease/Cirrhosis		
Crohn's Disease			Lung Disease or Asthma		
Congestive Heart Failure			Pancreatitis		
Colon Polyps			Seizures or Strokes		
Coronary Artery Disease			Sleep Apnea		
Depression			Stomach Ulcer		
Diabetes			Thyroid Problem		
GERD (Heartburn)			Ulcerative Colitis		

Any Other Condition:

4. List any surgeries you've had including the hospital and surgeon:

SURGERY	LOCATION	YEAR
Gallbladder		
Hysterectomy		
Appendectomy		
Cataract		
Hernia Repair		
Hip/Knee or Other Joint		
Heart Surgery		

Other Surgeries:

5. Habits:

- **Smoking: Do you currently smoke? ☐ Yes ☐ No How much per day?.....**
  Did you smoke previously? ☐ Yes ☐ No For how long and how much?.....
- **Alcohol Consumption ☐ Yes ☐ No**
  How much do you drink on average? ..... What kind?.....
- **Recreational Drug Use: ☐ Yes ☐ No Please specify .....**

- **Do you use over the counter Aspirin, Ibuprofen, or other pain/arthritis medicines?**
  How much on average per week? .....

6. Allergies: Please list any medications which you are allergic to and type of reaction

DRUG	ALLERGIC REACTION

7. CURRENT MEDICATIONS:

MEDICATION	DOSE	TIMES PER DAY

Any antibiotic use over the past 6 months:

8. FAMILY HISTORY: Please indicate relation if applicable

CONDITION	YES	NO	CONDITION	YES	NO
Breast cancer			Liver problems/cancer/Cirrhosis		
Colon cancer			Stomach cancer		
Colon polyps			Pancreatitis or Pancreatic cancer		
Crohn's Disease or Ulcerative Colitis			Uterine cancer		
Ovarian cancer					
Other conditions in parents or siblings:					

9. REVIEW OF SYSTEMS: Please check if you have any of the following symptoms:

	YES	NO		YES	NO
Fatigue			Abdominal pain		
Loss of appetite			Abdominal bloating		
Weight Loss			Diarrhea		
Fever or chills			Constipation		
Cough			Blood in stool		
Shortness of breath			Black stools		
Chest pain			Vomiting up blood		
Trouble swallowing			Generalized itching		
Painful swallowing			Joint pains		
Heartburn			Jaundice		
Reflux of stomach content			Mouth sores		
Nausea			Skin rash		