Milford Gastroenterology Associates, Inc.

Patient Information Form

Date: _____ Name: _____ DOB: _____

Personal and Social history:

Occupation(s): What is your employment status?

❑ Retired ❑ Unemployed ❑ Homemaker
❑ Employed; present occupation(s): _____
❑ Disabled; previous occupation(s): _____

Marital Status: ❑ Married ❑ Significant Other ❑ Widowed ❑ Divorced ❑ Single

Habits:
Do you ever drink alcohol? ❑ Yes ❑ No
If yes how much? _____

Has alcohol ever been a problem for you? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No (if Yes, please check the box below that best fits)
❑ Current Everyday ❑ Current Someday ❑ Former ❑ Never

Is there any history of illicit drug use? ❑ Yes ❑ No
Do you have tattoos? ❑ Yes ❑ No
Have you received a blood transfusion prior to 1992? ❑ Yes ❑ No

Family history

For each family member, please answer the following:

	(A) Alive or (**D)** Deceased: Ages	Significant Medical Conditions:
Mother:	_____	_____
Father:	_____	_____
Brothers:	_____	_____
Sisters:	_____	_____
Sons:	_____	_____
Daughters:	_____	_____

Is there any family history of: ❑ Colon cancer ❑Colon Polyps ❑ Ulcerative colitis ❑ Crohn's disease

❑Liver disease ❑ Esophageal cancer ❑Stomach cancer ❑any other cancers: _____

Past Medical and Surgical History:

List Medical Conditions:	List Surgical History:
_____	_____
_____	_____
_____	_____
_____	_____

Review of Systems:

Double sided

Please indicate whether you have ever had a medical problem related to any of the following areas. Please indicate problem.

❑ Yes ❑ No Difficulty/painful swallowing
❑ Yes ❑ No Heartburn/regurgitation
❑ Yes ❑ No Loss of appetite
❑ Yes ❑ No Nausea/vomiting
❑ Yes ❑ No Indigestion/digestive problems
❑ Yes ❑ No Food intolerance/diet restrictions
❑ Yes ❑ No Excessive belching/bloating/passing of gas
❑ Yes ❑ No History of ulcers
❑ Yes ❑ No Previous barium swallow/Previous upper endoscopy
❑ Yes ❑ No Abdominal pain/Hernia
❑ Yes ❑ No Jaundice/liver or gallbladder trouble/ hepatitis
❑ Yes ❑ No Change of bowel habits or bowel consistency
❑ Yes ❑ No Problems with constipation
❑ Yes ❑ No Problems with diarrhea
❑ Yes ❑ No Rectal bleeding/ Dark red or black stool/Mucus with stool
❑ Yes ❑ No Rectal pain/Hemorrhoids
❑ Yes ❑ No Previous Barium Enema/Previous Sigmoidoscopy/Previous Colonoscopy/Polyps
❑ Yes ❑ No Weight loss or gain in the past year
❑ Yes ❑ No Weakness/fatigue/fever/tiredness
❑ Yes ❑ No Rashes/mouth sores
❑ Yes ❑ No Loss of consciousness or fainting
❑ Yes ❑ No Stroke or difficulty moving an arm or leg
❑ Yes ❑ No Seizures or epilepsy
❑ Yes ❑ No Headaches
❑ Yes ❑ No Eyes – Glaucoma, Cataracts, other: _____
❑ Yes ❑ No Frequent sore throat/hoarseness/sores in mouth/lump sensation
❑ Yes ❑ No Ears, Nose, Sinuses, Tonsils: _____
❑ Yes ❑ No Chronic cough/ Breathing problems/Allergies
❑ Yes ❑ No Heart murmur/Heart infection
❑ Yes ❑ No Heart attack/Heart stents
❑ Yes ❑ No Chest pain/palpitations/irregular heartbeat
❑ Yes ❑ No Heart valve placement / Heart Bypass surgery
❑ Yes ❑ No Permanent pacemaker/Internal defibrillator
❑ Yes ❑ No Blood clots
❑ Yes ❑ No Anemia or other blood disorder
❑ Yes ❑ No Vascular problems
❑ Yes ❑ No Kidney or Bladder/urinary problems
❑ Yes ❑ No Bones, joints, muscles
❑ Yes ❑ No ***Females***: breast, ovaries or uterus
❑ Yes ❑ No ***Males***: prostate, penis, testes
❑ Yes ❑ No Depression, anxiety, panic, mood disorder Other: _____

Other: _____