Sierra Nevada Gastroenterology Medical Associates, Inc.
MEDICAL INFORMATION SHEET

Name: _____ DOB: _____ Date: _____

If you have any of these active or recent complaints, please check the box next to the complaint:

General
☐ chronic fatigue ☐ recent fevers
☐ weight loss (amount ____ since when? ____)

Bleeding Tendencies
☐ bruise easily / bleed too long

Ears, Eyes, Nose & Throat
☐ difficulty hearing ☐ wears hearing aid(s)
☐ poor vision ☐ chronic cough
☐ sinus trouble ☐ chronic hoarseness

Lungs
☐ shortness of breath ☐ wheezing

Heart
☐ chest pain ☐ irregular heartbeat ☐ ankle swelling

Skin
☐ rash ☐ itching ☐ skin fistula

Bones and Joints
☐ joint pain or swelling ☐ muscle aches
☐ muscle weakness ☐ back / neck pain

Urinary
☐ blood in urine ☐ painful urination
☐ decrease in urine force or flow
☐ urination at night (more than twice)

Neurologic
☐ tremor / hand shaking ☐ headaches (frequent)
☐ numbness or tingling ☐ memory loss

Gynecological
Date of last menstrual period _____

Gastrointestinal
☐ diarrhea ☐ constipation
☐ change in bowel habits ☐ bloating
☐ abdominal cramps ☐ gas
☐ blood in stool or on toilet paper with wiping
☐ fecal incontinence ☐ rectal urgency
☐ loss of appetite ☐ heartburn
☐ difficulty swallowing ☐ pain with swallowing
☐ nausea ☐ vomiting
☐ sense of early fullness after eating
☐ ascites (fluid in abdomen) ☐ jaundice

Psychiatric
☐ depressed mood ☐ anxiety
☐ prone to panic attacks

SOCIAL HISTORY
Occupation: _____
Personal: Married Single Widowed Domestic partner
Do you smoke or have you ever smoked? _____
How much? _____ How long? _____
When did you quit? _____
Please list your alcohol use: _____

FAMILY HISTORY Family member Age
Colon cancer / polyps _____
Stomach cancer _____
Bile duct cancer _____
Uterine / ovarian cancer _____
Other cancers _____
Colitis / Crohn's disease _____
Pancreatitis _____
Liver disease _____
Celiac sprue _____
Iron deficiency anemia _____
Heart disease _____

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PAST MEDICAL HISTORY (Please check all that apply)

Digestive Tract Disease ☐ No significant past medical history (please check only if nothing below applies)

☐ Colon polyps or cancer (when_____) ☐ Diverticulosis / Diverticulitis ☐ Hemorrhoids
☐ Ulcer disease (when_____) ☐ Colitis / Crohn's disease ☐ GERD / Acid reflux
☐ Barrett's esophagus ☐ Celiac sprue ☐ Pancreatitis
☐ Liver disease (type_____) ☐ IBS (irritable bowel syndrome) ☐ Other_____

Heart or Vascular Disease

☐ Heart attack (when_____) ☐ Angina ☐ Congestive heart failure
☐ Atrial fibrillation ☐ Other arrhythmia _____ ☐ Pacemaker
☐ Prior endocarditis (heart valve infection) ☐ Heart valve disease (type_____)
☐ High blood pressure ☐ Blood clot in veins (when_____) ☐ Aortic aneurysm

Lung Disease

☐ COPD / Emphysema ☐ Asthma ☐ Use home oxygen
☐ Other chronic lung disease (type _____)

Metabolic Disease

☐ Diabetes without insulin ☐ Diabetes with insulin ☐ Hypo / hyper thyroid disease ☐ High cholesterol

Neurologic Disease

☐ Stroke (when_____) ☐ TIA (when_____) ☐ Dementia
☐ Seizure history (last seizure_____) ☐ Neuropathy ☐ Other_____

Personal Cancer History

☐ Colon cancer (date:_____) ☐ Stomach cancer (date:_____) ☐ Lung (date:_____)
☐ Breast (date:_____) ☐ Prostate (date:_____) ☐ Other:_____

Bone / Muscle Disease

☐ Arthritis (Osteo / Rheumatoid) ☐ Chronic back problems ☐ Chronic neck problems
☐ Fibromyalgia ☐ Osteoporosis / osteopenia ☐ Other: _____

Miscellaneous

☐ Kidney disease (type_____) ☐ Dialysis dependent ☐ Anemia
☐ Depression / Bipolar disorder ☐ History of bleeding disorder ☐ Other: _____

PAST SURGICAL HISTORY (Please indicate approximate year beside the surgery marked) ☐ None

☐ Tonsillectomy ☐ Cholecystectomy (gallbladder removal) ☐ Appendectomy
☐ Hysterectomy / ovaries removed ☐ Back / spine surgery ☐ Hernia
☐ Breast surgery / biopsy ☐ Heart bypass / heart stent / angioplasty ☐ Carotid surgery
☐ Heart valve replacement (mitral aortic metal tissue) ☐ Pacemaker / debrillator implanted
☐ Other surgeries: _____

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MEDICINE ALLERGIES:

Medicine Type of Reaction

_____

_____

_____

_____

Any known allergies to Demerol? Yes No Any known allergies to Versed? Yes No

CURRENT MEDICINES: ☐ See Medicine List (check this box if you brought in a pre-printed list of your medicines. Otherwise, please write down the medicines you are currently taking)

Medicine Dose

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you regularly consume: ☐ aspirin ☐ Coumadin ☐ Plavix ☐ Excederin

☐ Ibuprofen or other similar anti-inflammatory medicines such as Motrin, Advil, Aleve, Naprosyn, Relafen, diclofenac

☐ Vitamin E supplements ☐ Gingko biloba ☐ Prescription iron supplements

_____ _____

Sign Date