Cape Fear Center for Digestive Diseases, PA

Patient Name: ____ Date of Birth: _____/_____/_____

Today's Date: _____/_____/_____ Age: ______ Married/Single/Divorced/Separated/Widowed (Please Circle)
Race ____________________ Sex: Male / Female (please circle)
Describe briefly the reason for your visit: ____
____
____
Primary Care Physician: ____________________________ Requesting Physician: ________________________________
Are you presently taking any of the following non-prescription medications? (Please Circle)
Aspirin Products: Yes/No If yes, please describe: ____
Arthritis Medications: Yes/No " " " " " ____
Laxatives/enemas: Yes/No " " " " " ____
Fiber Products: Yes/No " " " " " ____
Antacids/ulcer drugs: Yes/No " " " " " ____

List your other current medications/vitamin supplements; please enter the dose and frequency as well:

Name of Medication	Dosage	Frequency
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		

Name of Medication	Dosage	Frequency
9)		
10)		
11)		
12)		
13)		
14)		
15)		
16)		

Please list drugs/items (ie:Penicillin, Latex) you are allergic to:

Drug / Item	Reaction it causes

Which Pharmacy do you use? (Include location and phone number, if known)____________________________________
____

Past Medical History (If yes, to the following questions, please describe.):
Lung Disease: Yes/ No ____
Cancer (When/Where?): Yes / No ____
Radiation/Chemotherapy: Yes / No ____
Heart Disease: Yes / No ____

Diabetes	Yes / No	High Blood Pressure	Yes / No	Chest Pain	Yes / No
Arthritis	Yes / No	Rheumatic Fever/Heart	Yes / No	Colon Polyps	Yes / No
Anemia	Yes / No	Gall Bladder Disorder	Yes / No	Stomach Ulcer	Yes / No
Epilepsy	Yes / No	Difficulty Swallowing	Yes / No	Liver Disease	Yes / No

History of Psychiatric Illness:	Yes / No	History of blood clotting / bleeding disorders:	Yes / No
History of Tuberculosis:	Yes / No	History of Human Immunodeficiency Virus (HIV):	Yes / No
History of Hepatitis:	Yes / No	Any previous difficulty with sedation or anesthesia:	Yes / No

Surgical History (Include date(s) if known): ____
____
____

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Family History:	Father	Mother	P. Grandparents	M. Grandparents	Siblings	Children
Colon Cancer						
Colon polyps						
Stomach Cancer						
Pancreatic Cancer						
Crohn's or Colitis						
Stomach Ulcer						
Heart Disease						
Stroke						
Diabetes						
Iron Storage Disease (Hemochromatosis)						

OTHER: ____
____

Tobacco Use (Please describe present and past): (Example: 1 pack daily for 25 years, but discontinued 3 years ago):
____

Alcohol Use Yes/No (Amount/How often?) ____
Coffee/Tea/Sodas Yes/No (Amount/How often?) ____
Employment/Hobbies: ____

Review of Systems (Your History)

Change in bowel habits? Yes/No Comments: ____
Diarrhea? Yes/No ____
Constipation? Yes/No ____
Red blood in your stools? Yes/No ____
Black stools (like tar)? Yes/No ____
Pain before or after stools? Yes/No ____
Bloating / Distention? Yes/No ____
Heartburn / Indigestion often? Yes/No ____
Frequent nausea or vomiting? Yes/No ____
Recently lost weight? Yes/No ____
Recently gained weight? Yes/No ____
Snore loudly / not sleep well? Yes/No ____
Appetite? Good / Fair / None ____

Have you ever had any of these procedures?		Date	Findings
Colonoscopy	Yes / No		
Flexible Sigmoidoscopy	Yes / No		
Upper Endoscopy	Yes / No		
ERCP	Yes / No		
EUS	Yes / No		
CT scan of abdomen or GI tract (past 6 months)	Yes / No		
Ultrasound of abdomen or GI tract (past 6 months)	Yes / No		
MRI / MRCP	Yes / No		

Women Only:

Pregnant Yes / No Planning Pregnancy Yes / No
Breastfeeding Yes / No Contraceptive Type: ______________________

Patient Signature/Date: __________________________ Physician Signature/Date: ___________________________