UNIVERSITY of MARYLAND
SHORE MEDICAL GROUP

GASTROENTEROLOGY
511 Idlewild Avenue
Easton, MD 21601
410-822-6005/fax 410-822-9253

Name		Date
Date of Birth	**Height**	**Weight**

What is the main reason for your visit? ____

Have you had any previous evaluation of this? Y ☐ N ☐ If yes, please indicate when and where below:

____________________________________ Additionally, please indicate if you have had any of the following tests/hospital visits in evaluation of above ☐ Xrays ☐ Labs ☐ Endoscopy/Colonoscopy

☐ ER Visit ☐ Hospitalization ☐ Other: ____________ ☐ Specialist? Who: ________________

Family Doctor's Name	When did you last see your family doctor?

Review of Systems:

Please check the boxes of those conditions which affect you

☐ Skin Rash	☐ Shortness of Breath	☐ Difficulty Swallowing
☐ Mouth Sores	☐ Cough	☐ Heartburn
☐ Aching Joints	☐ Cough up Blood	☐ Constipation
☐ Fever	☐ Nausea	☐ Diarrhea
☐ Headache	☐ Vomiting	☐ Abdominal Pain
☐ Dizziness/lightheadedness	☐ Ankle Swelling	☐ Abdominal Bloating
☐ Frequent Urination	☐ Chest Pain	☐ Decreased Appetite
☐ Yellow Eyes	☐ Heart Disease	☐ Loss of Bowel Control/Soiling
☐ Epilepsy/Seizures	☐ Irregular Heartbeat	☐ Rectal Bleeding
☐ Past Stroke	☐ Wear Pacemaker	☐ Black or Tarry Stools
☐ Depression	☐ Take Coumadin/Blood Thinner	☐ Lactose Intolerance
☐ Wear Dentures	☐ Take Fluid Pills	☐ Unexpected Weight Loss

☐ Check this box if you take antibiotics prior to dental work or any other procedure and list why you take the antibiotic: ____

Past Medical History:

Please check the box if you have ever had these conditions:

General:

- ☐ Loose teeth
- ☐ High Blood Pressure
- ☐ Thyroid Disease
- ☐ HIV Positive
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Anemia
- ☐ Lupus
- ☐ Cancer: Type: __________
- ☐ Bleeding Disorder

Lungs:

- ☐ Tuberculosis
- ☐ Asthma
- ☐ Blood Clot in Lung
- ☐ Pneumonia
- ☐ Emphysema/COPD/oxygen use (circle those that apply)
- ☐ Sleep Apnea

Heart:

- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Bypass Surgery/Angioplasty/Stent (circle those that apply)
- ☐ Valve Disease
- ☐ Atrial Fibrillation
- ☐ Artificial Heart Valve
- ☐ Rheumatic Fever
- ☐ Endocarditis
- ☐ Pacemaker
- ☐ Defibrillator

Musculoskeletal:

- ☐ Arthritis
- ☐ Back or Neck Problems

PLEASE COMPLETE PAGE TWO OF THE HEALTH HISTORY FORM
→ → → → → → → →

HEALTH HISTORY (Page 2) **Name:** ______________________________

DO NOT LEAVE BLANK

***Gastrointestinal*:**

- [ ] Acid Reflux (GERD)
- [ ] Stomach Ulcers
- [ ] Diverticulosis
- [ ] Diverticulitis
- [ ] Irritable Bowel Syndrome
- [ ] Crohn's Disease/Ulcerative Colitis
- [ ] Colon Polyps
- [ ] Hemorrhoids
- [ ] Hepatitis/Liver disease
- [ ] Pancreatic Disease

Urogenital:

- [ ] Prostate Problems
- [ ] Kidney Stones
- [ ] Kidney Disorder/Kidney Failure/ Dialysis
- [ ] Menopause
- [ ] Last Menstrual Period (if applicable)____________________

Neuropsychiatric:

- [ ] Alzheimer's Disease
- [ ] Stroke: Date of last stroke: _________________________
- [ ] Seizures: Date of last seizure: _________________________
- [ ] Depression
- [ ] Other Psychiatric Illness
- [ ] Drug Abuse
- [ ] Developmental Disabilities? Describe: ____

Are there any other current or past medical conditions that we should be aware of? ____________________________________
____
____

Lifestyle

Does any of the following apply to you?
Had a tattoo, multiple body piercing, shared a razor, toothbrush or any item that could have carried infected blood, were sexually active with multiple partners, injected or inhaled drugs (even once), were imprisoned, had unprotected sex with anyone who fits any of the above descriptions.

☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No

Surgeries: (please check if you have had and list the year)

	Year		*Year*	
☐ Appendix:	________	☐ Colon Surgery:	__________	
☐ Uterus:	________	☐ Hemorrhoids:	__________	
☐ Ovaries:	________	☐ Upper Endoscopy:	__________	Where? _________________
☐ Gallbladder:	________	☐ Colonoscopy:	__________	Where? _________________
☐ Stomach Surgery:	________	☐ Joint Replacement	__________	Which One? _______________

☐ Please list any other operations and year: ____

***Family History*:**

Have your parents, siblings or children had **If so, who?** (i.e. mother, father, sister, brother, child)

- [ ] Colon Cancer. ____
- [ ] Colon Polyps. ____
- [ ] Crohn's Disease/Ulcerative Colitis. . . ____
- [ ] Breast/Ovarian/Endometrial Cancer (please circle which type)_________________________
- [ ] Esophageal Cancer. . . . . ____
- [ ] Stomach Cancer. . . . . ____
- [ ] Liver Disease. ____
- [ ] Liver Cancer. . . . . ____
- [ ] Celiac Disease. . . . . .____
- [ ] Pancreatic Cancer. . . . . ____
- [ ] Renal Cancer. ____
- [ ] Uterine Cancer. . . . . ____

Health Habits and Social History		**Circle One**		**Amount per day**
Do you smoke?	No	In the past	Yes	_______________
Do you chew tobacco?	No	In the past	Yes	_______________
Do you drink coffee?	No	In the past	Yes	_______________
Do you drink alcohol?	No	In the past	Yes	_______________

Occupation: ______________________________________ Marital Status: _____________________________

Patient Label

MEDICATIONS

DO NOT LEAVE BLANK **Name:**	**DO NOT LEAVE BLANK** **Birth Date:**

List All Food and Drug Allergies & Describe Reaction Below: OR ☐ No Allergies	☐ Check here if you take aspirin Aleve/Advil/Motrin/Mobic/Celebrex/Ibuprofen/Naproxen
	Do you take chronic medication for pain? ☐ Yes ☐ No What do you take?
	Are you allergic to IVP dye, latex, eggs, soybeans? ☐Yes ☐ No Describe Below:

Do you have a history of or a family history of problems with anesthesia/sedation including malignant hyperthermia?

☐ ***Yes*** ☐ ***No If yes, please explain:*** ____

List all prescription and non-prescription (over-the-counter) medications including vitamins, aspirin, and herbal preparations.

Name of Medication *£Home Medication List as Provided by Patient"*	Dose	How Often Taken?	Purpose	Date/ Time Last Taken FOR OFFICE USE ONLY