GASTROENTEROLOGY CLINIC OF SAN ANTONIO, P.A.

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Gastroenterology Clinic of San Antonio, P.A.

Patient Medical Information Sheet

8550 Datapoint Dr. Ste# 200
San Antonio, TX 78229

Patient Name: _____ DOB: _____ Age: _____ Date: _____
Primary Dr.: _____ Referring Dr. /Person: _____
Reason for today's visit: _____
_____

Medications currently taking (including birth control, vitamins, aspirin, ibuprofen, herbal supplements, etc.):

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Drug allergies and reactions:

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Medical diseases/Problems/Hospitalizations (example: diabetes, high blood pressure, depression, glaucoma, etc.):

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Operations and date (example: open heart surgery, gallbladder, hysterectomy, etc.):

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Family History: Do your parents, siblings or your children have any of the following? (check all that apply)

☐Celiac Sprue
☐Hemochromatosis
☐Colon Polyps
☐Diverticulosis/-it is
☐Gallbladder Stones
☐Colitis (Crohns or Ulcerative Colitis)
☐Irritable Bowel Syndrome
Cancer of: ☐Colon ☐Esophagus ☐Breast ☐Liver ☐Cervix ☐Pancreas ☐Ovaries ☐Stomach ☐Uterus
☐Cirrhosis of Liver
☐Hepatitis
☐Stomach Ulcers

Social History and Habits (Please check and give average amounts):

Smoke/Chew Tobacco: ☐Yes ☐No How many years? _____ Packs per day? _____
Drink Coffee: ☐Yes ☐No Number of cups/glasses per day? _____
Drink Beer, Wine or Hard Liquor: ☐Yes ☐No Number of drinks _____ per ☐day ☐week ☐month

Maritial Status: ☐Single ☐Married ☐Divorced ☐Widowed
Place of birth: _____ Level of Education: _____
Occupation: _____
Significant other's Occupation: _____
Children and Ages: _____

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Review of Systems: (please check any of the following symptoms or conditions you have had in the last 3 months)

GI

- ☐abdominal bloating, distension or gas
- ☐abdominal pain, burning or discomfort
- ☐black tarry stools
- ☐bright red blood in stools
- ☐constipation
- ☐diarrhea
- ☐difficulty swallowing
- ☐fatigue
- ☐fill up more easily at meals
- ☐heartburn or indigestion
- ☐hemorrhoids
- ☐jaundice
- ☐nausea
- ☐vomited blood or "coffee grounds"
- ☐vomiting

EYES

- ☐eye pain or redness
- ☐trouble with vision

MUSCULOSKELETAL

- ☐arthritis
- ☐muscle pain

PULMONARY

- ☐frequent cough
- ☐phlegm production
- ☐wheezing or asthma

GENITOURINARY

- ☐frequent urination at night
- ☐pain with urination
- ☐pain with intercourse

Last menstrual period: _____

# of pregnancies: _____

# of live births: _____

CONSTITUTIONAL

- ☐decrease in appetite
- ☐fever or chills
- ☐weight change in past 6 months

CARDIOVASCULAR

- ☐heart palpitations or pounding
- ☐heart problems
- ☐shortness of breath with exercise
- ☐shortness of breath with mild activity
- ☐sleep on more than 1 pillow
- ☐swelling of feet

ENT

- ☐hoarse voice ☐sore throat
- ☐lump in throat
- ☐recurrent mouth ulcers
- ☐sinus draining

HEMATOLOGIC/LYMPH

- ☐bleed or bruise easily

NEUROLOGICAL

- ☐dizzy spells
- ☐seizures or black outs
- ☐HA's

PSYCHIATRIC

- ☐anxiety or depression

_____ _____

Patient signature **Date**