Gastroenterlogy **David Siegel, M.D.** 14999 Health Center Drive, 201
Ritu Sachdev, M.D. Bowie, MD 20716

Please fill out the information below to the best of your knowledge

Patient Name:____Birth Date: _______________________
Referring Physician: ____Cardiologist:______________________
Chief complain/reason for visit: ____

____
____
____
____

Medication (include OTC and supplements):

____
____

Past Medical History **Have you ever had the following? If Yes give date of diagnosis:**

AIDS or HIV	No yes	High Blood pressure	No yes	Stroke / CVA	No yes
Hepatitis B	No yes	High cholesterol	No yes	Blood clot condition	No yes
Hepatitis C	No yes	Heart attack	No yes	Kidney problem	No yes
Tuberculosis	No yes	Heart disease	No yes	Kidney failure on dialysis	No yes
Colitis/Crohn's	No yes	Asthma / COPD	No yes	Blood transfusion	No yes
Infectious disease	No yes	Sleep Apnea	No yes	Arthritis	No yes
Hives or eczema	No yes	Diabetes	No yes	Back / spine problem	No yes
Cancer Type?	No yes	Epilepsy / convulsion	No yes	Diverticulosis	No yes
Stomach ulcer	No yes	Thyroid disease	No yes	Colon Polyp	No yes

Other medical condition:____
Date of last colonoscopy/endoscopy:____
Allergies (Drug and food): ____Latex allergy _______________
Previous hospitalizations: _______________ **(illness)** ________________________ **(Hosp)** _______**yr** ________
Previous Surgery: ☐ Brain surgery ☐ Stomach removed/repaired ☐ Jaw surgery ☐ Thyroid removed ☐ Tonsil/adenoids removed

☐ Lung surgery ☐Gastric Bypass ☐Esophagus surgery ☐ Colon resection ☐ Appendix removed ☐ Gall bladder removed

☐ Breast surgery/ Mastectomy Left or Right ☐ Heart Valve replacement ☐ Prostate surgery ☐ Heart bypass surgery ☐ Hernia repair

☐ Joint replacement Other surgery:____

Last menstrual period: ____________ **Are you pregnant:**_____**Planning Pregnancy:**_____

Hysterectomy: ____________Tubal ligation___________________
# of pregnancies ___ # birth_______ # C-Section:_________Last Pap Smear________

Patient Social History: Occupation: ____
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow
Sexual Preference Men Women Both
Use of drugs ☐ Never Recreation drug user Type/Frequency: _________________
Use of caffeine ☐ Coffee Tea Soda Drinks per day: _________________
Use of anti-inflammatory (non-steroid) Type ______________ Frequency:__________________________
Use of alcohol ☐ Never Rarely☐ Moderate☐ Daily Which kind?: Wine ☐ Beer ☐ Liquor Quantity: ______
Use of dairy W/ indigestion? Yes / no
Which kind?: Milk Cheese Cottage Cheese Ice Cream Yogurt
Use of tobacco ☐ Never Currently, packs per day: ________ for __________ years.
☐Previously, but quit ____ yrs ago for ____ yrs _____packs per day

Family Medical History: Check and circle all applied.

Family history of	Relation	Age of onset	If deceased, cause of death:
Colon cancer			
Stomach cancer			
Breast cancer			
Uterine cancer			
Prostate cancer			
Colon polys			
Gallbladder complications			
Liver disease			
Gastrointestinal/ Pancreatic disease			
Other medical problem/ issues:			

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Review of systems: Please indicate any personal history below:

Constitutional symptoms
Good general health lately ….no yes
Recent weight change……….no yes
Fever…………………………no yes
Fatigue……………………....no yes
Headaches…………………...no yes

Eyes
Eye disease or injury…….. …no yes
Wear glasses/contact lenses… ….no yes
Blurred or double vision…….no yes

Ears/Nose/Mouth/Throat
Hearing loss or ringing…. …..no yes
Earaches or drainage…… …..no yes
Chronic sinus problems/
Rhinitis………………………no yes
Nose bleeds…………….……no yes
Mouth sores…………………no yes
Bleeding gums…………. …...no yes
Bad breath……….. …………no yes
Bad taste…………….………no yes
Sore throat/voice change……….no yes
Swollen glands in neck……...no yes

Cardiovascular
Chest pain/angina pectoris…..no yes
Palpitation………………… ..no yes
Shortness of breath w/walking
Or lying flat………………. ...no yes
Swelling of the feet/ankles/feet. ..no yes

Respiratory
Do you have a persistent cough or
Throat clearing not associated with a
Known illness (lasting more than 3
wks)……………………….…no yes
Spitting up blood…………..…no yes
Shortness of breath…………..no yes
Wheezing……………………no yes

Gastrointestinal
Loss of appetite……………...no yes
Difficulty swallowing………..no yes
Lump in throat……………….no yes
Change in bowel movements…...no yes
Nausea or vomiting………….no yes
Frequent diarrhea……………no yes
Painful bowel movements…...no yes
Constipation…………………no yes
Rectal bleeding/blood in stool…..no yes
Abdominal pain……………...no yes
Black / tarry stool……………no yes
Heart burn…………….…… no yes

Genitourinary
Frequent urination…………...no yes
Burning or painful urination...no yes
Blood in urine………………..no yes
Strain to urinate……………..no yes
Incontinence or dribbling……no yes
Kidney stones…………….…no yes
Female-pain with periods……no yes
Female-irregular periods…….no yes

Musculoskeletal
Joint pain……………………no yes
Joint stiffness or swelling…...no yes
Muscle pain or cramps………no yes
Back pain……………………no yes
Difficulty in walking………...no yes

Integumentary (skin, breast)
Rash or itching………………no yes
Change in skin color………...no yes
Varicose vein………………..no yes
Breast pain/lump..…………..no yes
Breast discharge……………..no yes

Neurological
Frequent or recurrent headache…no yes
Light headed or dizzy………..no yes
Convulsions or seizure………no yes
Numbness or tingling sensation....no yes
Tremors……………………..no yes
Paralysis……………………no yes
Head injury…………………no yes
Fainting……………………..no yes

Psychiatric
Memory loss or confusion…..no yes
Nervousness…………………no yes
Depression…………………...no yes
Insomnia……………………..no yes
Panic Attack……………… no yes

Endocrine
Glandular or hormone problem…no yes
Excessive thirst or urination….no yes
Heat intolerance……………..no yes
Cold intolerance……………..no yes

Hematologic/lymphatic
Slow to heal after cut………..no yes
Bleeding or bruising tendencies...no yes
Anemia………………………no yes
Enlarged glands……………...no yes

Allergic/immunologic
History of skin reaction or other
adverse reaction to:
Latex ……………………………… no yes
Penicillin or other antibiotics..no yes
Morphine, Demerol, or
other narcotic………………...no yes
Novocain or other anesthetic…...no yes
Aspirin or other pain remedies….no yes
Tetanus antitoxin or other
Serums…………………………no yes
Iodine, Methylate ………… no yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the Doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

____________________________ Signature of Patient/parent/or legal guardian _________________ Date

<u>Doctor's Review</u>

Doctors Signature/ date: ____