# WOODHOLME
GASTROENTEROLOGY ASSOCIATES

A LifeBridge Health Partner

Board Certified in Gastroenterology

## PATIENT INFORMATION

Name _____ Title _____

Race_____ Preferred Language_____ Email_____

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Patient declines to specify

Contact Preference: ❑ Letter ❑ Phone ❑ Patient Portal/Email ❑ Patient declines to specify

I would like to receive preventive care and follow-up care reminders: ❑ Yes ❑ No

Our Patient Portal allows you to communicate with our practice and review your medical history.
Please click yes to indicate you consent to access information on line: ❑ Yes ❑ No

I consent to obtaining a history of my medications purchased at pharmacies: ❑ Yes ❑ No

Pharmacy:

Name:_____ Address:_____ Phone: _____

Name:_____ Address:_____ Phone: _____

## ALLERGIES

❑ No known allergies ❑ No known drug allergies ❑ Other Allergies

❑ Codeine ❑ IV Contrast ❑ Latex ❑ Penicillin _____

## IMMUNIZATIONS

❑ None

❑ Flu Vaccine ❑ Hep A ❑ Hep B ❑ Pneumococcal ❑ Other _____

## PAST OR PRESENT MEDICAL ILLNESSES / PROBLEMS

### GASTROINTESTINAL

❑ Barrett's Esophagus ❑ Celiac Sprue ❑ Colon Cancer ❑ Crohn's Disease

❑ Diverticulitis ❑ Diverticulosis ❑ Esophageal Cancer ❑ Gallstones

❑ Gastrointestinal Bleeding ❑ Hemorrhoids ❑ Hepatitis A ❑ Hepatitis B

❑ Hepatitis C ❑ Irritable Bowel Syndrome (IBS) ❑ Liver Cancer

❑ Pancreatitis ❑ Pancreatic Cancer ❑ Reflux, Esophageal ❑ Stomach Cancer

❑ Ulcer ❑ Ulcerative Colitis ❑ Other_____

### CARDIAC

❑ Atrial Fibrillation ❑ Heart Attack ❑ Heart Murmurs ❑ Pacemaker or Defibrillator

❑ Stents ❑ Other _____

### CANCER (NON GI)

❑ Breast Cancer ❑ Gyn Cancer ❑ Lung Cancer ❑ Prostate Cancer

❑ Other _____

### OTHER

❑ Anemia ❑ Arthritis ❑ Asthma ❑ Bleeding Disorder

❑ Depression ❑ Diabetes ❑ Dialysis ❑ Emphysema

❑ Endometriosis ❑ Glaucoma ❑ High Blood Pressure ❑ High Cholesterol

❑ History of Anxiety Disorder ❑ History of Blood Transfusion ❑ HIV ❑ Kidney Disease

❑ Kidney Stones ❑ Lupus ❑ Peripheral Vascular Disease ❑ Rheumatoid Arthritis

❑ Seizure disorder ❑ Sexually transmitted disease(s) ❑ Skin disease ❑ Sleep Apnea

❑ Stroke ❑ Thyroid Disease ❑ Urinary Infections ❑ Other _____

## PREVIOUS GI PROCEDURES

❑ None ❑ Bravo capsule (pH probe) ❑ Capsule Endoscopy ❑ Colonoscopy

❑ Endoscopy/EGD ❑ ERCP ❑ Sigmoidoscopy ❑ Hiatal Hernia ❑ Other_____

## PREVIOUS SURGERIES

❑ None ❑ Appendectomy ❑ Cardiac Surgery

❑ Colon Surgery/Colostomy ❑ Gallbladder removed ❑ Gastric bypass/obesity surgery

❑ Heart valve replacement/repair ❑ Hernia repair/surgery ❑ Hysterectomy

❑ Joint Surgery/replacement ❑ Liver Surgery ❑ Mastectomy

❑ Tonsillectomy ❑ Other_____

## FAMILY MEDICAL HISTORY

| DIAGNOSES | Mother | Father | Sister | Brother | Grandmother | Grandfather | Other |
|---|---|---|---|---|---|---|---|
| Celiac Disease | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Ulcerative Colitis | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Crohn's Disease | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Diabetes | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Esophageal Cancer | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| GYN Cancer | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Heart Disease | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Hypertension | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Liver Disease | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Pancreatic Disease | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Stomach Cancer | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Thyroid Disease | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Colon Polyps | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Colon Cancer | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Age for Colon Cancer | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

❑ Adopted ❑ No knowledge of family history No family history of ❑ Colon Cancer ❑ Polyps

❑ Other Family Illness _____

## SOCIAL HISTORY

Occupation | Number of Children

**MARITAL STATUS**

❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Civil Union ❑ Other

**ALCOHOL** ❑ None ❑ Social ❑ Daily ❑ Quit

**TOBACCO**

❑ Current every day smoker ❑ Current some day smoker ❑ Former smoker ❑ Never smoked

❑ Smoker, current status unknown ❑ Light tobacco smoker ❑ Heavy tobacco smoker ❑ Unknown if ever smoked

❑ Other_____

## ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS?

### GASTROINTESTINAL

| ❑ NONE | YES | NO |
|---|---|---|
| Abdominal pain | ❑ | ❑ |
| Belching | ❑ | ❑ |
| Black stool | ❑ | ❑ |
| Bloating | ❑ | ❑ |
| Blood in stool | ❑ | ❑ |
| Change in bowel habits | ❑ | ❑ |
| Constipation | ❑ | ❑ |
| Diarrhea | ❑ | ❑ |
| Gas | ❑ | ❑ |
| Heartburn | ❑ | ❑ |
| Hemorrhoids | ❑ | ❑ |
| Hiccups | ❑ | ❑ |
| Jaundice | ❑ | ❑ |
| Loss of appetite | ❑ | ❑ |
| Milk/lactose intolerance | ❑ | ❑ |
| Nausea | ❑ | ❑ |
| Pain with bowel movement | ❑ | ❑ |
| Rectal bleeding | ❑ | ❑ |
| Rectal itching | ❑ | ❑ |
| Rectal pain | ❑ | ❑ |
| Stomach burning | ❑ | ❑ |
| Stool incontinence | ❑ | ❑ |
| Trouble swallowing | ❑ | ❑ |
| Vomiting | ❑ | ❑ |

### CARDIOVASCULAR

| ❑ NONE | YES | NO |
|---|---|---|
| Angina/chest pressure | ❑ | ❑ |
| Ankle swelling | ❑ | ❑ |
| Chest pain | ❑ | ❑ |
| Irregular heart beat | ❑ | ❑ |

### CONSTITUTIONAL

| ❑ NONE | YES | NO |
|---|---|---|
| Fatigue | ❑ | ❑ |
| Fever | ❑ | ❑ |
| Sweats | ❑ | ❑ |
| Weight gain | ❑ | ❑ |
| Weight loss | ❑ | ❑ |

### ENMT

| ❑ NONE | YES | NO |
|---|---|---|
| Bleeding gums | ❑ | ❑ |
| Burning tongue | ❑ | ❑ |
| Change in vision | ❑ | ❑ |
| Dry eyes | ❑ | ❑ |
| Dry mouth | ❑ | ❑ |
| Eye pain | ❑ | ❑ |
| Hoarseness | ❑ | ❑ |
| Mouth sores | ❑ | ❑ |
| Nose bleeds | ❑ | ❑ |
| Sore throat | ❑ | ❑ |

### ENDOCRINE

| ❑ NONE | YES | NO |
|---|---|---|
| Excessive thirst | ❑ | ❑ |
| Hair change | ❑ | ❑ |
| Excessive urination | ❑ | ❑ |

### GENITOURINARY

| ❑ NONE | YES | NO |
|---|---|---|
| Blood in urine | ❑ | ❑ |
| Change in urinary frequency | ❑ | ❑ |
| Difficulty w/ urination | ❑ | ❑ |
| Irregular menstruation | ❑ | ❑ |
| Sexual difficulty | ❑ | ❑ |

### HEMATOLOGIC/LYMPHATIC

| ❑ NONE | YES | NO |
|---|---|---|
| Enlarged glands | ❑ | ❑ |
| Prolonged bleeding | ❑ | ❑ |

### SKIN

| ❑ NONE | YES | NO |
|---|---|---|
| Itching | ❑ | ❑ |
| Rashes | ❑ | ❑ |

### MUSCULOSKELETAL

| ❑ NONE | YES | NO |
|---|---|---|
| Muscle weakness | ❑ | ❑ |
| Stiff joints | ❑ | ❑ |
| Swollen joints | ❑ | ❑ |

### NEUROLOGICAL

| ❑ NONE | YES | NO |
|---|---|---|
| Frequent headaches | ❑ | ❑ |
| Numbness or tingling | ❑ | ❑ |
| Paralysis | ❑ | ❑ |
| Seizures | ❑ | ❑ |

### RESPIRATORY

| ❑ NONE | YES | NO |
|---|---|---|
| Cough | ❑ | ❑ |
| Shortness of breath | ❑ | ❑ |

### PSYCHIATRIC

| ❑ NONE | YES | NO |
|---|---|---|
| Anxiety | ❑ | ❑ |
| Depression | ❑ | ❑ |
| Difficulty sleeping | ❑ | ❑ |
| Memory loss/confusion | ❑ | ❑ |