WOODHOLME
GASTROENTEROLOGY ASSOCIATES

Board Certified in Gastroenterology

PATIENT INFORMATION

Name ______________________ Title ______________

Race __________ Preferred Language ______________ Email ______________

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Patient declines to specify Gender: ❑ Male ❑ Female

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 ❑ Defibrillator/AICD ❑ Heart Attack ❑ Heart Murmurs
❑ Pacemaker ❑ Stents ❑ Other ______________

CANCER (NON GI)

❑ Breast Cancer ❑ Gynecologic Cancer ❑ Lung Cancer ❑ Prostate Cancer
❑ Other ______________

OTHER

❑ Alzheimer's ❑ Anemia ❑ Arthritis ❑ Asthma
❑ Bleeding Disorder ❑ Dementia ❑ Depression ❑ Diabetes
❑ Dialysis ❑ Emphysema ❑ End Stage Renal Disease ❑ Endometriosis
❑ Frailty ❑ Glaucoma ❑ High Blood Pressure ❑ High Cholesterol
❑ History of Anxiety Disorder ❑ History of Blood Transfusion ❑ HIV ❑ Kidney Disease
❑ Kidney Stones ❑ Lupus ❑ Oxygen Dependency ❑ Parkinson's
❑ Peripheral Vascular Disease ❑ Rheumatoid Arthritis ❑ Seizure Disorder ❑ Sexually Tansmitted Disease(s)
❑ Skin Disease ❑ Sleep Apnea ❑ Stroke ❑ Thyroid Disease
❑ Urinary Infections ❑ Wheelchair Bound ❑ Other ______________

PREVIOUS GI PROCEDURES

❑ None ❑ Bravo capsule (pH probe) ❑ Capsule Endoscopy ❑ Colonoscopy, Year done: ______

❑ 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	❑	❑
COVID	❑	❑
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	❑	❑