



# Gastroenterologists, P.C.

Specialists in Digestive Diseases & Liver Disorders  
931 8th Avenue S.E., Cedar Rapids, IA 52401  
319/366-8695 FAX 319/366-0795

Patient No. \_\_\_\_\_

Date \_\_\_\_\_

## PATIENTS PERSONAL HISTORY

**Confidential Record:** Information contained here will not be released except when you have authorized us to do so.

Last Name		First	Middle	Birth Date		Birth Place	
Address		City	State	Zip	Home Phone		Business Phone
Occupation		Medicare No.	Medicaid No.		Sex	Marital Status	Religion
Insurance Company				Insurance No.		M	F

Person to Notify \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Date of Last Physical Examination \_\_\_\_\_ Doctor \_\_\_\_\_

Family or Referring Physician \_\_\_\_\_ Address \_\_\_\_\_

Hospital Preference:  Mercy  St. Luke's

FAMILY HISTORY			If Living		If Deceased	
	Sex	Age	Health	Age at Death	Cause	
Father						
Mother						
Brothers/Sisters* (Circle Sex)						
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				
Husband/Wife						
Sons/Daughters* (Circle Sex)						
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				

\* Since some names may be used for either men or women, please circle sex for each Brother, Sister, Son or Daughter

Do you have any blood relatives who have had: (Circle and give details)

Colon Cancer or Polyps \_\_\_\_\_

Cirrhosis of the Liver \_\_\_\_\_

Colitis or Crohn's Disease \_\_\_\_\_

Early onset Heart Disease \_\_\_\_\_

Celiac Sprue \_\_\_\_\_

### PERSONAL HABITS: (Circle)

Yes No Tobacco Cigarettes  Packs per day \_\_\_\_\_ Years \_\_\_\_\_ Quit 19 \_\_\_\_\_  
 Pipe  Cigars  Smokeless

Yes No Caffeine Coffee \_\_\_\_\_ Cups per Day  
 Tea \_\_\_\_\_ Cups per Day  
 Pop \_\_\_\_\_ Cans per Day

Yes No Alcohol Average Daily/Weekly Consumption \_\_\_\_\_  
 Previous Heavy Usage Yes No

Yes No IV or Recreational Drugs  Now  Past

**MEDICATIONS:** Please bring all of your prescription medications with you for all appointments.

Do you routinely use the following nonprescription medications? (If so, please bring these with you)

Yes	No	Aspirin, Ibuprofen, Naproxen, Ketoprofen
Yes	No	Antacids, Cimetidine/Tagamet, Pepcid, Zantac, Axid

Drug allergies and type of reaction (Please list):  Latex Sensitivity

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Please list all surgeries and dates:

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Please circle all your medical conditions:

Other (Please List)

High Blood Pressure	Cancer (Type)	_____
Heart Disease/Murmur/Valve Disease	Ulcer	_____
Diabetes	Colitis	_____
Thyroid Disease	Hepatitis/Jaundice	_____
Seizures	Internal Bleeding	_____
Asthma/Emphysema/TB	Stroke	_____
Bleeding Disorder/Easy Bleeding/Bruising	Anemia/Blood Disorder	_____
Kidney Disease	Anxiety/Depression	_____

Have you previously had these tests? (Circle)

Yes	No	UGI Series	Date?	_____
Yes	No	LGI/Barium Enema	Date?	_____
Yes	No	Endoscopy/Sigmoidoscopy/Colonoscopy	Date?	_____
Yes	No	CT Abdomen +/- Abdominal Ultrasound	Date?	_____
Yes	No	Recent blood testing	Date?	_____ Where? _____



