ALL ISLAND GASTROENTEROLOGY & LIVER ASSOCIATES, P. C.

Patient Name	Date of Birth	Today's Date

Reason for today's visit ____

____

Current Medications (name and dose) Include vitamins, aspirin, antacids, laxatives, etc.

1. ______________________ 6. ______________________
2. ______________________ 7. ______________________
3. ______________________ 8. ______________________
4. ______________________ 9. ______________________
5. ______________________ 10. ______________________

Personal Medical History: Please circle those that apply

Acid Reflux	**Colitis**	**Hepatitis**	**Osteoporosis**
Alcoholism	**Depression**	**High Blood Pressure**	**Parasites**
Anemia	**Diabetes**	**High Cholesterol**	**Stroke**
Anorexia/Bulimia	**Diverticulitis**	**HIV**	**Substance Abuse**
Athritis/gout	**Emphysema**	**Irritable bowel**	**Thyroid disease**
Asthma	**Epilepsy/seizures**	**Kidney Disease**	**Tuberculosis**
Blood clots	**Gallstones**	**Liver disease**	**Ulcers (Stomach)**
Blood transfusions	**Heart diease**	**Lung Disease**	**Ulcerative colitis**
Cancer	**Heart Arrhythmia**	**Mental Illness**	**Uterine Bleeding**
Crohn's Disease			

Other:

Allergies or reactions to medicine/latex or other (name and type of reaction)

1. ____
2. ____
3. ____

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____________________	____________________	____________________
Patient Name	**Date of Birth**	**Today's Date**

Previous GI Procedures and Tests (year, results, doctor's name)

Colonoscopy ______________________________
Sigmoidoscopy ______________________________
Upper Endoscopy (EGD) ______________________________
Video Capsule Study (Pillcam) ______________________________
Upper GI Series ______________________________
Sonogram ______________________________
Barium Enema ______________________________

Previous Surgeries (type and year)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Previous Hospitalizations (diagnosis or reason, year, hospital)

1. ______________________________
2. ______________________________
3. ______________________________

Family Medical History (please circle those that apply)
Medical details about your family (diseases, types of cancer, etc.)

Colon Cancer/polyps	Father______________________________
Crohn's Disease ulcerative colitis	Mother______________________________
Liver Disease	Siblings ______________________________
Pancreatic Cancer	Children ______________________________
Gall Bladder Disease	Paternal Grandmother ____________________
Stomach or esophagus cancer	Paternal Grandfather ____________________
Diabetes	Maternal Grandmother ____________________
Coronary artery disease	Maternal Grandfather ____________________

Personal Information:

Marital Status ______________________________
Occupation ______________________________
Alcohol use ______________________________
Tobacco use ______________________________
Country of birth ______________________________