MEDICAL WEST
GASTROENTEROLOGY
an affiliate of the UAB HEALTH SYSTEM
985 9th Avenue SW, Suite 307, Bessemer, AL 35022 • 205-481-7384

Name _____ Today's Date _____

Social Security No. _____ Date of Birth _____

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced Gender ☐ Male ☐ Female

Home Address _____
Street City State Zip

Phone Numbers: Home _____ Cell _____ Work _____

EmailAddress _____ Preferred Contact Method Phone Mail Email

EMPLOYMENT

Employer _____ Dept./Title _____

Employer's Address _____
Street City State Zip

Employer's Phone _____

EMERGENCY CONTACTS

Spouse/Companion/Guardian:
Name & Relationship _____ Phone _____

Address _____
Street City State Zip

Nearest relative or friend not living with you:
Name & Relationship _____ Phone _____

Address _____
Street City State Zip

FAMILY PHYSICIAN

Name _____ Phone _____

PREFERRED PHARMACY

Pharmacy Name _____ Phone _____

Pharmacy Address _____
Street City State Zip

REFERRAL

Referred by _____
Address/Phone _____
Street City State Zip Phone

PERSON RESPONSIBLE FOR PAYMENT

Name _____ Phone _____

Address _____
Street City State Zip

INSURANCE INFORMATION

Primary _____ Policy No. _____ Group No. _____
Name of Insured & Relationship _____ DOB _____

Secondary _____ Policy No. _____ Group No. _____

Name of Insured & Relationship _____ DOB _____

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Today's Date _____

Name_____ **Age**_____ **Date of Birth**_____

SOCIAL HISTORY

Health History Questionnaire **All questions contained in this questionnaire are strictly confidential and will become part of your medical record.**			
Name:		☐ **M** ☐ **F**	**DOB:**
Marital status	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Employment	☐ Full Time ☐ Part Time ☐ Homemaker ☐ Retired ☐ Disabled ☐ Student ☐ Other		
	Current Occupation:		
	Past Occupation:		
Personal Safety	Do you live alone? ☐ Yes ☐ No If no? ☐ With Family ☐ With Spouse ☐ Other		
	Do you have frequent falls?	☐ Yes ☐ No	
	Do you have vision or hearing loss?	☐ Yes ☐ No	
	Do you have an Advance Directive and /or a Living Will?	☐ Yes ☐ No	
	Would you like information on Advance Directives?	☐ Yes ☐ No	
HEALTH HABITS AND PERSONAL SAFETY			
All questions contained in this questionnaire will be kept strictly confidential.			
Exercise	☐ No exercise		
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x weekly for 30 minutes)		
	☐ Regular vigorous exercise (i.e., work or recreation 4x weekly for 30 minutes)		
Diet	Eating Problem	☐ Yes ☐ No	
	Comment:		
Alcohol	Do you drink alcohol?	☐ Yes ☐ No	
	How many drinks per day?		
Tobacco	Do you use tobacco	☐ Yes ☐ No	
	☐ Cigarettes pkg/day_____	☐ Chew #/day _____	☐ Pipe #/day _____	☐ Cigars #/day _____
	_____# of years	☐ Previous user	_____ # of years quit	
Drugs	Do you currently use recreational or street drugs?	☐ Yes ☐ No	
	What kind?		

FAMILY HISTORY

	Living	Deceased	Colon polyps	Colon cancer	Liver disease	Pancreas disease	Crohn's disease	Ulcerative colitis	Stomach cancer
Mother									
Father									
Sister									
Brother									
Maternal Grandmother									
Maternal Grandfather									
Paternal Grandmother									
Paternal Grandfather									
Other									
Other									

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Name_____ **Date of Birth**_____

ALLERGIES

Name of Drug		Type of reaction	Comments
Penicillin	☐ Yes ☐ No		
Sulfa	☐ Yes ☐ No		
Codeine	☐ Yes ☐ No		
Iodine	☐ Yes ☐ No		
Latex	☐ Yes ☐ No		
Other	☐ Yes ☐ No		
Other	☐ Yes ☐ No		

MEDICATIONS - Please list all of your current prescription and non-prescription medications, vitamins and supplements.

Medication Name	Strength	Frequency Taken

Pharmacy Information		
Pharmacy Name:	**Pharmacy Location:**	**Pharmacy Phone #:**

SURGERIES / PROCEDURES

☐ NONE	☐ Colostomy	☐ Groin hernia	☐ Hiatal hernia repair	☐ Obesity surgery	☐ Thyroid
☐ Appendectomy	☐ C-section	☐ Heart bypass	☐ Hysterectomy	☐ Ovary	☐ Tonsillectomy
☐ Breast	☐ EGD	☐ Heart stent	☐ Joint replacement	☐ Prostate	☐ Tubal ligation
☐ Colon surgery	☐ ERCP	☐ Heart valve	☐ Kidney	☐ Sigmoidoscopy	☐ Uterus
☐ Colonoscopy	☐ Gallbladder	☐ Hemorrhoid surgery	☐ Liver biopsy	☐ Stomach	☐ OTHER

PREVIOUS HOSPITALIZATIONS

Reason	Date	Reason	Date

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Name_____ **Date of Birth**_____

Personal Health History

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and Dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ Measles, Mumps, Rubella
	☐ Other	
Previous Performed Tests	☐ Mammogram	Date Performed
	☐ Pap Smear	Date Performed
	☐ Bone Density Study	Date Performed
	☐ Colonoscopy	Date Performed
	☐ PSA	Date Performed
	☐ TB Skin Test	Date Performed
	☐ Dilated Eye Exam	Date Performed
	☐ Other:	Date Performed

PAST MEDICAL HISTORY

☐ Acid reflux	☐ Chronic sinusitis	☐ Groin hernia	☐ Kidney stones	☐ Polio
☐ Anal fissure	☐ Cirrhosis of liver	☐ Heart attack	☐ Lupus / Scleroderma	☐ Psoriasis
☐ Anemia	☐ Colon cancer	☐ Heart failure	☐ Migraines	☐ Radiation therapy
☐ Arthritis	☐ Colon polyps	☐ Heart murmur	☐ Milk intolerance	☐ Rheumatic fever
☐ Artificial heart valve	☐ Crohn's disease	☐ Hepatitis	☐ Mitral valve prolapse	☐ Sciatica
☐ Asthma	☐ Depression	☐ Hiatal hernia	☐ Multiple sclerosis	☐ Seizures
☐ Bleeding disorder	☐ Diabetes	☐ High blood pressure	☐ Osteoporosis	☐ Sleep apnea
☐ Blood clots	☐ Diverticulitis	☐ High cholesterol	☐ Ovarian cyst	☐ Stomach ulcer
☐ Blood transfusion	☐ Duodenal ulcer	☐ High triglycerides	☐ Pacemaker	☐ Stroke or paralysis
☐ Cancer	☐ Emphysema	☐ HIV or AIDS	☐ Pancreatitis	☐ Tuberculosis (TB)
☐ Chest pain / angina	☐ Fatty liver	☐ Irregular heart beat	☐ Parkinson's disease	☐ TB skin test positive
☐ Chronic anxiety	☐ Gallstones	☐ Irritable bowel syndrome	☐ Peptic ulcer	☐ Thyroid disease
☐ Chronic lung disease	☐ Glaucoma	☐ Kidney disease / failure	☐ Phlebitis	☐ Ulcerative colitis
☐ Chronic lung disease	☐ Gout	☐ Kidney infection	☐ Pneumonia	

List any medical problems that other doctors have diagnosed:

Name_____ **Age**_____ **Date of Birth**_____

Referred by: _____ **Primary Care Physician:** _____

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Other Physicians involved in your healthcare: _____

Describe the reason(s) for your visit: _____

_____

Review of Systems

General	**Gastrointestinal (cont'd)**	**Musculoskeletal**	**Ear, Eyes, Nose, Mouth, Throat**
□ fever or chills	□ poor appetite	□ stiff or painful joints	□ hearing loss
□ loss of appetite	□ rectal bleeding	□ swollen joints	□ ear pain/ringing
□ unintentional weight gain	□ rectal pain or itching	□ back pain	□ mouth ulcers/sores
□ unintentional weight loss	□ regurgitation of food	□ muscle pain	□ poor dentition
□ weakness, fatigue	□ soiling / bowel incontinence		□ nose bleeds
	□ vomiting blood	**Hematologic**	□ visual changes
Gastrointestinal		□ frequent bruising	□ enlarged or swollen glands
□ abdominal distention	**Cardiovascular**	□ bleeding doesn't stop easily	
□ abdominal pain/cramping	□ chest pain or tightness		**Neurologic**
□ belching	□ rapid or irregular heart beat	**Endocrine**	□ numbness or tingling
□ black stools	□ swelling of legs	□ heat or cold intolerance	□ dizziness or lightheadedness
□ blood in stool	□ varicose veins	□ excessive thirst or urination	□ vertigo
□ change in bowel habits		□ steroid therapy (prednisone)	□ headaches
□ constipation	**Respiratory**		□ weakness in arms or legs
□ diarrhea	□ chronic cough	**Dermatologic**	□ blurred vision
□ difficulty swallowing	□ wheezing	□ rash or hives	□ difficulty with memory
□ fat intolerance	□ shortness of breath	□ itching	
□ full after eating small amounts	□ need for oxygen therapy	□ tattoos	**Psychiatric**
□ gas / bloating			□ anxiety
□ heartburn	**Urinary**	**Reproductive-MALE**	□ depression
□ indigestion	□ pain/difficulty with urination	□ discharge from penis	□ panic attacks
□ hemorrhoids	□ frequent urination	□ testicular pain or lump	□ tired on waking up in morning
□ jaundice /yellowing of the skin	□ blood in urine		
□ mucus in stool	□ incontinence of urine	**Reproductive-FEMALE**	**Immunizations**
□ nausea or vomiting		□ heavy periods	□ Hepatitis A
□ pain with swallowing		Date of last period	□ Hepatitis B
			□ Pneumovax

Reviewed by Doctor _____ **Date** _____