

Cleveland Gastroenterology Associates, P.A.

Patient's Name _____ Today's Date _____
Birthdate ____/____/____ Sex _____ Chart # _____
Chief Complaint(reason for visit) _____ Duration(when first noticed) _____
Primary Care (Family) Doctor _____
Were you referred for today's visit or is this a follow-up
visit? _____
If referred, list referring physician _____

REVIEW OF SYSTEMS

If you have recently had any of the following, check appropriately.

- GENERAL Wt. loss Wt. gain Fatigue Fever Cancer _____
- SKIN Rash Lumps Itching Hair change/loss
- HEAD Headache Injury
- EYES Vision Glaucoma Cataract Redness Pain
- EARS Ringing Dizziness Pain Deafness or use of hearing aid
- NOSE/SINUSES Cold Nosebleed Discharge Sinus trouble
- MOUTH/THROAT Bleeding gums Dentures Hoarseness Sore throat
- NECK "Swollen glands" Goiter
- BREAST Lumps Discharge Date of last exam/mammogram _____
- RESPIRATORY Cough Wheezing Emphysema TB Snoring Use CPAP
- CARDIAC High Blood Pressure Chest Pain Palpitations Shortness of breath
- GI Ulcers Jaundice Polyps Constipation Diarrhea
- GU Urinary frequency Urinary hesitation Urinary infections Stones
 Hernia Venereal disease(s) Menstrual irregularity Abortion
 Menopause (at what age? _____)
- PERIPHERAL VASCULAR Leg cramps Pain with walking Swelling
- MUSCULOSKELETAL Joint/pain stiffness Gout Osteoporosis
- NEUROLOGICAL Fainting/Blackouts Seizures Weakness Numbness Tremors
- PSYCHIATRIC Suicide attempt Depression Anxiety Nervous Breakdown
- DIABETES

Patient Profile

Married Divorced Single Separated Widowed
Occupation _____ Since Yr. _____
Check if retired:
Hobbies/Interests _____
Time since last complete medical examination _____
Do you smoke? _____ If yes, how much? _____
Do you chew tobacco? _____ If yes, how much? _____
Do you drink alcohol? _____ If yes, how much? _____
Have you ever used illegal drugs? _____ If yes, what type(s)? _____

HEREBY CERTIFY THAT THE ABOVE INFORMATION I HAVE PROVIDED IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient Signature _____ Date _____

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Patient Name _____ Chart # _____

Birthdate ____/____/____ Today's Date _____

PAST MEDICAL HISTORY/HOSPITALIZATIONS/SURGERIES

List illnesses or operations and approximate year. EXCLUDE NORMAL PREGNANCIES.

19 _____	20 _____
19 _____	20 _____
19 _____	20 _____
19 _____	20 _____
19 _____	20 _____

HEALTH OF FAMILY

	Good	Poor	Died	Cause of death	Age
Father(natural) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Mother(natural) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Brothers/Sisters _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Spouse _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
# Children _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

FAMILY HISTORY-Gastrointestinal (Digestive) Disease

	Relative
Gallstones _____	
Ulcer _____	
Polyps _____	
Pancreatitis _____	
Liver Disease (Cirrhosis, Hepatitis) _____	
Diabetes _____	
Cancer _____	