

 **GASTROENTEROLOGY ASSOCIATES OF SUFFOLK, P.C.**
Specialists in Digestive Problems

BOARD CERTIFIED IN GASTROENTEROLOGY, HEPATOLOGY & BILIARY DISEASES

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To The Patient:

We have designed this form in order to assist us in obtaining your complete medical history. This is necessary so that we will be able to view your gastroenterological problem in light of your overall medical and personal background. We will be discussing all of these items in detail when we meet with you. If you are unable to answer any of the questions, please so indicate. Your cooperation is appreciated. Thank you.

Patient's Name: _____ Birth Date: _____ Sex: _____

Referred By: _____ Family Physician: _____

What is your main complaint and reason for coming here?

MEDICAL HISTORY: List all operations you have had and approximate dates:

List all major illnesses (example: high blood pressure, asthma, heart disease, diabetes, etc.):

Previous hospitalizations (when and why)

Are you allergic to any medications:

What medications, if any, are you currently taking:

Have you ever had _____ G.I. Series _____ Barium Enema _____ Gallbladder X-rays or Sonograms
_____ Sigmoidoscopy _____ Colonoscopy _____ Gastroscopy

PERSONAL HISTORY:

Do you smoke tobacco (how much): _____

Alcohol: Do you drink _____ never _____ socially _____ more than 3 days per week?

If you do drink more than 3 days per week, how much do you consume in an "average week"? _____

Have you ever had a drinking problem or been a heavy drinker _____ yes _____ no?

Are you often _____ depressed _____ tense or nervous:

FAMILY HISTORY: Are there any illnesses that run in your family?														
	FATHER		MOTHER		BROTHER			SISTER			CHILDREN			
Age (if living)														
Health (G) good (B) bad														
Breast Cancer														
Colon Cancer														
Other Cancer														
Tuberculosis														
Diabetes														
Heart Trouble														
Colon Polyps														
Ileitis or Colitis														
Ulcer														
Liver Disease														
Pancreatitis														
Age (at death)														
Cause of death														

REVIEW OF SYSTEMS: Are you now or have you ever been frequently troubled in the past by?					
	YES	NO		YES	NO
Eye Problems			Ulcer Disease		
Frequent Headaches			Colitis		
Ear Problems			Ileitis (Crohn's Disease)		
Blackout spells or convulsions			Diarrhea		
Thyroid disease			Constipation		
Cough			Blood in stools		
Difficulty breathing			Black tarry stools		
Chest pain			Trouble Swallowing		
Trouble sleeping			Heartburn		
Difficulty urinating			Liver Disease		
Kidney or bladder disease			Gallbladder disease		
Arthritis			Yellow jaundice		
Swelling of legs or ankles			Loss of appetite		
Paralysis			Skin rash		
Difficulty with coordination			Pancreatitis		
Menstrual irregularity			Easy bruising		
Fever			Diverticulosis		
Unexplained weight loss			Intestinal polyps		