GASTROINTESTINAL MEDICINE ASSOCIATES, INC.

www.GIMEDRI.com

Name____**Date of Birth**_______________

Gastrointestinal Medicine Associates, Inc.
Medical History

Asthma / COPD	O Yes	O No	Obstructive Sleep Apnea	O Yes	O No
Diverticulitis	O Yes	O No	Crohn's Disease / Ulcerative Colitis	O Yes	O No
High Blood Pressure	O Yes	O No	Celiac Disease	O Yes	O No
High Cholesterol	O Yes	O No	Barrett's Esophagus	O Yes	O No
Heart disease	O Yes	O No	Peptic ulcer disease	O Yes	O No
Diabetes Mellitus	O Yes	O No	Pancreatitis	O Yes	O No
Irritable Bowel Syndrome	O Yes	O No	Ulcerative colitis	O Yes	O No
Inflammatory Bowel Disease/Colitis	O Yes	O No	Gall stones	O Yes	O No
Personal History of Colon cancer	O Yes	O No	Anemia	O Yes	O No
Personal History of Colon polyp	O Yes	O No	GERD/Reflux	O Yes	O No
Liver disease	O Yes	O No	Hemorrhoids	O Yes	O No
If Yes, what condition(s)?______________________			Family History of colon cancer	O Yes	O No
			Family History of Colon polyp	O Yes	O No
Have you ever been diagnosed with H.Pylori?	O Yes	O No			
Do you have a Cardiac Defibrillator or Pacemaker?	O Yes	O No			

Do you have any other chronic medical conditions: ______________________________________

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Have you had your flu shot since the most recent September 1st?___________________

If you are 65 or older, have you had your pneumonia vaccine yet? _____________________

OVER ➡

V1.1

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Social History

Marijuana Use (in any form) O Yes O No
Travel (outside the USA) O Yes O No
Tattoos O Yes O No
Cocaine O Yes O No
IV Drugs O Yes O No
Caffeine O Yes O No
Smoking O Yes O No packs/day_____how long_____quit____
Alcohol O Yes O No drinks/day_____drinks/week_____

Family History

Mother O Alive O Deceased Age_________
O Colon cancer O Colon Polyps O Inflammatory bowel disease O Liver disease
O Other____

Father O Alive O Deceased Age_________
O Colon cancer O Colon Polyps O Inflammatory bowel disease O Liver disease
O Other____

Siblings O Alive O Deceased Age_________
O Colon cancer O Colon Polyps O Inflammatory bowel disease O Liver disease
O Other____

Children O Alive O Deceased Age_________
O Colon cancer O Colon Polyps O Inflammatory bowel disease O Liver disease
O Other____

Surgical History-Please list all surgeries, including Colonoscopy, Metal Implants

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Medication List

Do you take:
Aspirin O Yes O No
Over the counter pain medication O Yes O No
Diabetes medication O Yes O No
Plavix, Coumadin, or other blood thinner O Yes O No

ALLERGIES: ____

Signature: ____ **Date:** _______________