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Wake Gastroenterology

A Division of Wake Internal Medicine Consultants, Inc.

Date: _____

Patient Name: _____ DOB: ___ / ___ / ___ Age: _____

Referring Physician/Practice Name: _____

Reason for today's visit: _____

Past or present medical illnesses, operations or hospitalizations: _____

Past GI Studies or evaluations: _____

Date of last Colonoscopy: _____ Upper Endoscopy: _____ Flex Sig: _____

Performed by Dr. _____ Facility Location: _____

Family History (list any major medical problems):

Father: _____ PAT grandparents: _____

Mother: _____ MAT grandparents: _____

Brother(s): _____ Sister(s): _____

Please check "Yes" or "No" and indicate length of time the symptoms were present:

<u>SYMPTOMS</u>	Yes	No	Length of time
Heartburn	_____	_____	_____
Indigestion	_____	_____	_____
Difficulty Swallowing	_____	_____	_____
Painful Swallowing	_____	_____	_____
Nausea or vomiting	_____	_____	_____
Abdominal or stomach pain	_____	_____	_____
Bloating	_____	_____	_____
Diarrhea, constipation or change in bowel habit	_____	_____	_____
Passing blood or black tarry bowel movements	_____	_____	_____
Loss of appetite	_____	_____	_____
Weight loss/gain	_____	_____	_____
Liver or gallbladder trouble	_____	_____	_____
History of Jaundice or Hepatitis	_____	_____	_____

SYSTEMS REVIEW

Patient Name: _____ Date: _____

Please check those that apply to you:

GENERAL

- Fever
- Chills
- Sweats
- Anorexia
- Fatigue
- Malaise
- Weight Loss

EYES

- Blurring
- Double vision
- Irritation
- Discharge
- Vision loss
- Eye pain
- Pain with bright light

EARS/NOSE/THROAT

- Ear pain or discharge
- Ringing in the ear
- Decreased hearing
- Nasal obstruction or discharge
- Nosebleeds
- Sore throat
- Hoarseness
- Dysphagia (difficulty swallowing)

CARDIOVASCULAR

- Chest pains
- Skipping or fast heartbeat
- Fainting (syncope)
- Shortness of breath(dyspnea) on exertion
- Shortness of breath(dyspnea) when lying down
- Awakening from sleep with shortness of breath
- Swelling of feet

RESPIRATORY

- Cough
- Shortness of breath
- Excessive Sputum
- Coughing up blood
- Wheezing

GENITOURINARY

- Vaginal discharge or sores
- Incontinence
- Painful Urination
- Blood in Urine
- Urinary frequency
- Amenorrhea
- Menorrhagia
- Abnormal vaginal bleeding
- Pelvic pain
- Pain with sexual intercourse

MUSCULOSKELETAL

- Back pain
- Joint pain
- Joint swelling
- Muscle cramps
- Muscle weakness
- Stiffness
- Arthritis

SKIN

- Rash
- Itching
- Dryness
- Suspicious lesions

NEUROLOGIC

- Transient paralysis
- Weakness
- Tingling in extremities
- Seizures
- Fainting
- Tremors
- Room Spinning

PSYCHIATRIC

- Depression
- Anxiety
- Memory loss
- Mental disturbance
- Suicidal Ideation
- Hallucinations
- Paranoia

ENDOCRINE

- Cold intolerance
- Heat intolerance

- Excessive need to drink fluids
- Excessive need to eat
- Excessive urination
- Weight change

HEME/LYMPHATIC

- Abnormal bruising
- Bleeding
- Enlarged lymph nodes

ALLERGIC/IMMUNOLOGIC

- Hives
- Hay fever
- Persistent infections
- HIV exposure

SOCIAL

Occupation: _____

Caffeine
If yes, how many cups per day: _____

Smoking
If yes, how many cigarettes per day: _____

Alcohol
If yes, how many drinks per day: _____

Exercise
If yes, how many days per week: _____

Do you use sugar substitutes?
Yes No

Do you use milk products?
Yes No

Do you use drugs for reasons that are not medical?
Yes No
If yes, please list:

Do you use anti-inflammatories? (NSAIDS)
Yes No