



MIDDLESEX GASTROENTEROLOGY ASSOCIATES

If you would like assistance with completing this form, please do not hesitate to ask. Our staff will be happy to help you in the privacy of our office.

- Name (include middle initial):
Date of Birth:
Who referred you to MGA (how did you hear about us)?
Who is your primary physician & gyn & surg (if applic) ?
What is the reason for your visit?
Have you ever seen a gastroenterologist before? Y N If yes, who?

Current Employment Status:

- Student, Employed, Unemployed, Retired
Your job title:
Your employer (if applicable):

- List all medications, including herbal supplements and over the counter medications, along with the current dosage (indicate "NONE" if appropriate)

Table with 3 columns: Medication, Dosage, Frequency

Do you take Coumadin (warfarin), Plavix (clopidogrel), or injectable heparin? Y N
If yes, who prescribed the blood thinners? For what purpose?

- List medication, food (including shellfish), IV dye & latex allergies:

- List all prior operations with month and year (indicate "NONE" if appropriate)

Table with 2 columns: Surgery, Month / Year

Name: _____ Date of Birth: _____

● Mark all **medical** illnesses which you currently have or have had in the past:

Heart:

- Angina Atrial Fibrillation High Cholesterol Pacemaker
 Arrhythmia Defibrillator High Blood Pressure Rheumatic Fever
 Artificial Heart Valve Heart Attack Low Blood Pressure Stroke

Digestive:

- Bacterial Overgrowth Diverticulosis Hepatitis Reflux
 Barrett's Esophagus Esophagitis Irritable Bowel Ulcerative Colitis
 Celiac Sprue Gallstones Lactose Intolerance Ulcers
 Colon Polyps H. Pylori Liver Cirrhosis
 Crohn's Disease Hemorrhoids Pancreatitis

Cancer:

- Breast Ca Pancreas Ca Stomach Ca Leukemia / Lymphoma
 Colon Ca Prostate Ca Throat Ca Other: _____
 Esophagus Ca Skin Ca Uterine Ca _____

Lung:

- Asthma Emphysema Hay Fever Tuberculosis

Blood:

- Bleeding Disorder B12 Anemia Past history of Anemia Other Anemia
 Blood Clots Iron-deficiency Anemia Worsening Anemia

Liver:

- Alcoholic liver disease Cirrhosis Fatty liver disease Hepatitis C Other liver disease

Endocrine:

- Diabetes – Insulin Dep. Obesity Overactive Thyroid
 Diabetes – Non-Insulin Dep. Osteoporosis Under active Thyroid Post-menopausal

Other:

- Endometriosis HIV/AIDS Osteoarthritis
 Glaucoma Latex Allergy Rheumatoid Arthritis

List any other illnesses.

Do you have sleep apnea? Y N	Have you had a Hepatitis A vaccine? Y N unsure
If Yes >>>> Do you use CPAP / BIPAP? Y N	Have you had a Hepatitis B vaccine? Y N unsure
Do you snore loud enough to be heard through a closed door? Y N	Have you had blood transfusions? Y N unsure
Do you often feel tired, fatigued or sleepy during the day? Y N	
Has anyone observed you stop breathing during your sleep? Y N	

Name: _____ Date of Birth: _____

● Mark all illnesses, if known, in related **family** members, list approx age at diagnosis and age at death.

FAMILY HISTORY		Father	Mother	Brother			Sister			Any other family history?
				#1	#2	#3	#1	#2	#3	
Cancer	Colon									
	Esophageal									
	Stomach									
	Pancreatic									
	Prostate									
	Breast									
	Lung									
	Ovarian									
	Uterine									
Bleeding	Stomach Ulcers									
	Diverticulosis									
	Hemorrhoids									
	Other bleeding									
Other GI	Colon Polyps									
	H. Pylori Infection									
	Lactose Intolerance									
Gallbladder, Liver, or Pancreas	Gallbladder Stones									
	Pancreatitis									
	Hepatitis									
	Hemochromatosis									
	Wilson's disease									
Intestinal	Celiac Sprue									
	Crohn's Disease									
	Ulcerative Colitis									
	Colitis									
Other Medical	Diabetes									
	Hypertension									
	Heart Disease									
	Alcohol Abuse									
	Other:									
●	If alive, list current age:									
●	If deceased, list age at death:									

What is your current estimated weight in pounds? _____ height in inches? _____

Are you adopted? Y N	Have you ever smoked or used tobacco? Y N
What is your marital status? <i>Please circle one</i> Married Divorced Single	If yes then, how many packs per day? _____ How many years? _____
How many children do you have? _____	Did you quit (when)?
Do you drink Coffee/Tea? Y N If yes: cups/day _____	Do you drink alcohol? Y N If yes: drinks/day _____ Quit Date? _____
	Have you ever used injection or street drugs? Y N

Name: _____ Date of Birth: _____

● Please circle "Y" if you experience any of these symptoms (defaults to No if not circled)

Lack of Energy	Y	Breast Lump	Y
Trouble Sleeping	Y	Could be Pregnant	Y
Weight Loss	Y	Heavy / Painful Menses	Y
Weight Gain	Y	Joint Swelling	Y
Fevers	Y	Joint Redness	Y
Constipation / Straining	Y	Gout	Y
Blood in Bowel Movements	Y	Muscle Aches	Y
Vomiting Blood	Y	Rash / Growth on skin	Y
Heartburn/Indigestion	Y	Jaundice / Itching	Y
Difficulty Swallowing	Y	Paralysis	Y
Diarrhea - rarely	Y	Stroke	Y
Diarrhea - severe or mild(circle one)	Y	Seizures	Y
Chest Pain	Y	Loss of Memory	Y
Irregular Heartbeat	Y	Depression	Y
Palpitations	Y	Suicide Attempts	Y
Swollen Legs	Y	Anxiety	Y
Fainting	Y	Diabetes	Y
Shortness of Breath	Y	Excessive Thirst	Y
Wheezing	Y	Bleeding	Y
Coughing up Blood	Y	Easy Bruising	Y
Asthma	Y	Visual Changes	Y
Frequent Urination	Y	Glasses/Contact Lenses	Y
Blood in Urine	Y	Migraine Headaches	Y
Difficulty Urinating	Y	Cold Sores	Y

Patient (or Representative) Signature: _____ Date: _____

To be completed by the physician

Date reviewed: _____ Any Changes? Y N _____
 MD Signature _____

Date reviewed: _____ Any Changes? Y N _____
 MD Signature _____

Date reviewed: _____ Any Changes? Y N _____
 MD Signature _____

Date reviewed: _____ Any Changes? Y N _____
 MD Signature _____