WEST GASTROENTEROLOGY MEDICAL GROUP

NEW PATIENT VISIT

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____

VISIT DATE: _____

REFERRING DOCTOR (NAME, ADDRESS, PHONE#)

_____

_____

_____

_____

PATIENT PHARMACY:

PHARMACY NAME: _____

ADDRESS: _____

CITY,STATE, ZIP: _____

PHONE NUMBER: _____

CHIEF COMPLAINT (REASON FOR VISIT): _____

_____

CHRONIC CONDITIONS:

HIGH BLOOD PRESSURE (401.9)	YES	NO
DIABETES TYPE I (250.01) TYPE 2 (250.00)	YES	NO
CHOLESTEROL (272.0)	YES	NO
HEPATITIS (TYPE)	YES	NO
A (070.1) B (070.32) C (070.54)	YES	NO
CANCER TYPE: _____	YES	NO
HEART TROUBLE (429.2)	YES	NO
CONVULSIONS (780.39)	YES	NO
STROKE (V12.54)	YES	NO
ARTHRITIS (714.9) RHEUMATOID (714.0)	YES	NO

MEDICINE ALLERGIES: ___ **NONE**

_____

_____

_____

_____

_____

CURRENT MEDICATION (NAME AND DOSAGE) OR CHECK HERE ____ TO SEE LIST

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PATIENT PAST MEDICAL HISTORY (PLEASE CIRCLE)

alcoholism	CHF	hemachromatosis	parkinson disease
anemia	COPD	hyperlipidemia	peptic ulcer dx
asthma	coronary artery dx	hypertension	prostate cancer
blood transfusion	crohns disease	irritable bowel syn.	prostate hyperplasia
celiac disease	CVA	kidney disease	seizures
cholelithiasis	diabetes mellitus	kidney stones	thyroid disease
renal failure	diverticular dx	liver cancer	ulcerative colitis
cirrhosis	GERD (reflux)	migraine headaches	varices esophageal
colon cancer	GOUT	obesity	varices gastric
colon polyps	hepatitis exposure	pancreatitis	Other: _____

PATIENT SURGICAL HISTORY (NAME AND YEAR):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

PATIENT SOCIAL HISTORY

MARITAL STATUS

__SINGLE __MARRIED __DIVORCED __WIDOWED

USE OF TOBACCO

__NEVER __CURRENT __PREVIOUSLY

USE OF ALCOHOL

__NEVER __CURRENT __PREVIOUSLY

USE OF DRUGS

__NEVER __CURRENT __PREVIOUSLY

FAMILY MEDICAL HISTORY

	ALIVE & WELL	DISEASE	IF DECEASED, CAUSE OF DEATH
FATHER	_____	_____	_____
MOTHER	_____	_____	_____
SIBLINGS	_____	_____	_____

WEST GASTROENTEROLOGY MEDICAL GROUP **NEW PATIENT ROS**

PATIENT NAME: _____ **DOB:** _____

CONSTITUTIONAL SYMPTOMS		
Chills	NO	YES
Fever	NO	YES
Malaise	NO	YES
Weight loss	NO	YES
HEENT		
Double Vision	NO	YES
Ear Infection	NO	YES
Eye pain	NO	YES
Nasal congestion	NO	YES
Sinus infection	NO	YES
Sore throat	NO	YES
Glaucoma	NO	YES
RESPIRATORY		
Dyspnea	NO	YES
Frequent cough	NO	YES
Pleuritic pain	NO	YES
Wheezing	NO	YES
CARDIOVASCULAR	NO	YES
Chestpain	NO	YES
Extremity edema	NO	YES
Palpitations	NO	YES
GASTROINTESTINAL		
Abdominal pain	NO	YES
Change in bowel habits	NO	YES
Constipation	NO	YES
Diarrhea	NO	YES
Dysphagia	NO	YES
Heartburn	NO	YES
Hematesis	NO	YES
Hematochezia	NO	YES
Loss of appetite	NO	YES
Melena	NO	YES
Nausea	NO	YES
Reflux	NO	YES
Vomiting	NO	YES
GENITOURINARY		
Dysuria	NO	YES
Hematuria	NO	YES
Urinary frequency	NO	YES
Urinary incontinence	NO	YES
Urinary retention	NO	YES

FEMALE ONLY REPRODUCTIVE		
Breast lumps	NO	YES
Breast pain	NO	YES
Vaginal discharge	NO	YES
MALE ONLY		
Penile Discharge	NO	YES
Sexual Dysfunction	NO	YES
Testical pain	NO	YES
METABOLIC/ENDOCRINE		
Cold intolerance	NO	YES
Excessive thirst	NO	YES
Heat intolerance	NO	YES
NEUROLOGICAL		
Dizziness	NO	YES
Headache	NO	YES
Numbness	NO	YES
Tremors	NO	YES
Vertigo	NO	YES
PSYCHIATRIC		
Anxiety	NO	YES
Depression	NO	YES
Increased stress	NO	YES
INTEGUMENTARY		
Contact Allergy	NO	YES
Hives	NO	YES
Pruritus	NO	YES
Rash	NO	YES
MUSKULOSKELETAL		
Back pain	NO	YES
Myalgia	NO	YES
Joint pain	NO	YES
HEMATOLOGIC/LYMPHATIC		
Easy bleeding	NO	YES
Easy bruising	NO	YES
Lymphadenopathy	NO	YES
IMMUNOLOGIC		
Asthma	NO	YES
Chemicals in work place	NO	YES
Food Allergies	NO	YES
Immunosuppression	NO	YES
Seasonal allergies	NO	YES