DIGESTIVE DISEASE SPECIALISTS
5350 Distinction Way, Prescott, AZ 86301
928-445-4066 | www.prescottdigestive.com

PATIENT INFORMATION

PLEASE READ AND COMPLETE

FULL NAME_____ STREET ADDRESS_____

CITY_____ STATE _____ ZIP _____ HOME PHONE_____

AGE_____ BIRTH DATE _____ GENDER: M F CELL PHONE_____

MARITAL STATUS (circle one or more) single married divorced separated widowed

SOCIAL SECURITY NUMBER _____ PERSONAL E-MAIL _____

EMPLOYER _____ ADDRESS _____

WORK TELEPHONE _____ OCCUPATION _____

_____

SPOUSE INFORMATION

NAME _____ EMPLOYER _____

EMPLOYER ADDRESS _____ PHONE _____

SPOUSE'S SOCIAL SECURITY NUMBER_____ DATE OF BIRTH_____

==========

NAME OF PATIENT'S HEALTH INSURANCE 1_____ 2_____

NAME OF INSURED _____PHARMACY_____

==========

NAME OF PERSON TO NOTIFY IN EMERGENCY (NOT IN YOUR HOUSEHOLD):

_____RELATIONSHIP_____PHONE_____

==========

PRIMARY CARE PROVIDER: _____

WHO ADVISED YOU TO BE SEEN IN THIS OFFICE? _____

PLEASE LIST ANY OTHER DOCTOR'S NAMES THAT YOU ARE CURRENTLY SEEING_____

_____

I AUTHORIZE THE FOLLOWING NON-MEDICAL PERSONS TO BE INFORMED ABOUT MY HEALTH STATUS OR TEST RESULTS

_____

I AUTHORIZE DIGESTIVE DISEASE SPECIALISTS STAFF TO CONTACT ME OR LEAVE MESSAGES FOR ME USING THE INFORMATION LISTED ON THIS PAGE. LIST ANY DESIRED RESTRICTIONS:

_____

_____

PATIENT'S SIGNATURE DATE 0217

DIGESTIVE DISEASE SPECIALISTS
5350 Distinction Way, Prescott, AZ 86301
928-445-4066 | www.prescottdigestive.com

MEDICAL HISTORY -- Please fill out all three pages. Thank you!

1. Name: _____ 2. Date_____

3. Please list any medications that you have had bad reactions to or circle none. NONE
_____

4. List all medications you are currently taking (include any over-the-counter medications). If you know the dosage (milligrams, grams, tbsp., tsp., etc.), please include this, and note the number of tablets you are taking, and how often.

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

5. Please list any other medications, that you are no longer currently taking, but have taken in the past month:
_____

6. What is your approximate weight now? _____ One year ago?_____ Five years ago? _____

7. Do you smoke cigarettes? YES NO If yes, approximately how much do you smoke per day?_____
If yes, at what age did you begin smoking? _____ If you have quit smoking, for how many years did you smoke prior to quitting?_____ If you have quit smoking, how long ago did you quit? _____

8. How often do you take any products containing aspirin? (such as; Anacin, Bufferin, Midol, Excedrin, Alka-Seltzer, etc.) _____

9. How many cups of coffee (containing caffeine) do you drink per day, on the average? _____

10. How many soft drinks (containing caffeine) do you drink per day, on the average? _____

11. How many drinks of alcohol do you consume in an average 7 day period of time? (Please include all alcoholic drinks, including beer and wine.) _____

12. FAMILY HISTORY

	IF LIVING		IF DECEASED	
	AGE	HEALTH	AGE AT DEATH	CAUSE OF DEATH
FATHER				
MOTHER				
SPOUSE				
BROTHERS/SISTERS:				
1.				
2.				
3.				
4.				
5.				

CHILDREN	AGE	HEALTH	AGE AT DEATH	CAUSE OF DEATH
1.				
2.				
3.				
4.				
5.				
6.				

13. Have any of your blood relatives ever had stomach cancer, colon cancer, other cancers, diabetes, heart disease, blood disorders, hemophilia, liver disease, hepatitis, ulcers, or inflammatory bowel disease? If yes, please list which relative, and for each relative list which of the above problems he or she had, and at what age:

A._____
B._____
C._____
D._____
E._____
F._____

14. Please list all prior surgery you have had:

	Year of surgery	Type of surgery	Hospital	City
A.				
B.				
C.				
D.				
E.				
F.				
G.				

15. COLORECTAL CANCER SCREENING: (circle or fill in the blank)
When was your last test for fecal occult blood?_____ NEVER What was the result? POS NEG UNSURE
Have you ever had a colonoscopy, sigmoidoscopy, or barium enema? COLON SIGMOID BE NONE
When? _____ What was the result? NORMAL OTHER_____

16. If you have <u>recently</u> been experiencing any of the following symptoms, then following the listed symptom please check YES, and if possible give details of the problem you are experiencing. Check NO, if you are not experiencing the symptom.

SYMPTOM	YES	NO	DETAILS
Skin rash			
Excessive itching			
Excessive bleeding if cut			
Bleeding gums			
Excessive bruising			
Excessive hair loss or growth			
Painful or enlarged glands			
Unusual growths on or under the skin			
Joint or muscle problems			

Recent weight gain or loss without diet change			
Excessive thirst or hunger			
Frequent headaches or migraines			
Frequent dizzy spells			
Seizures			
Visual problems other than needing glasses			
Hearing problems			
Sinus problems			
Breast problems or lumps			
Difficulty breathing			
Persistent cough			
Coughing up blood			
Do you wake up at night due to being short of breath			
Do you wake up at night due to drenching sweats			
Irregular heart beats or palpitations			
Chest pain			
Shortness of breath with light exertion			
Shortness of breath when lying flat			
Leg pain with exertion			
History of rheumatic fever			
Pain or difficulty with urination			
Wake up frequently at night to urinate			
Menstrual problems			

17. Have you ever had hepatitis or "yellow jaundice"? YES NO

18. Have you ever used intravenous "street" or illegal drugs? YES NO

19. Have you ever received blood transfusions? YES NO

20. Have you had any blood work in the past year? YES NO If yes, at what lab?_____

21. Have you had any GI x-rays in the past three years? YES NO If yes, where?_____

Thank you for filling out this form, which will hopefully enable you to receive more complete and better care. If you have any further comments or any particular concerns that you would like to discuss at your appointment, please list them below (or continue on the back of this page, if necessary).

_____
_____
_____
_____
_____
_____
_____0217