

# Alliance Digestive Disease Consultants Medical Group

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**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

**Age:** \_\_\_\_\_

## Past Medical History

**Please Check All That Applies**

- Diabetes Mellitus
- Hypertension (High blood pressure)
- Tuberculosis
- Asthma
- Emphysema/Bronchitis
- Chronic Obstructive Pulmonary Disease
- Sleep apnea
- Coronary Artery Disease
- Myocardial infarction (heart attack)
- Angina
- Irregular heart beat
- Peptic Ulcer Disease (stomach ulcers)
- Liver Disease \_\_\_\_\_
- Cirrhosis of the liver
- Viral Hepatitis (Please circle: A, B, C)
- Jaundice
- Gallstones
- Hemorrhoids
- Pancreatitis
- Chronic Kidney Disease
- Hemodialysis (Kidney Dialysis)
- Thyroid disease
- Anemia
- Cancer, breast
- Cancer, colon.
- Cancer, esophagus
- Cancer, pancreas
- Cancer, rectum
- Cancer, stomach
- Colon diverticulosis
- Colon polyps
- Other: \_\_\_\_\_

## Past Surgical History

**Please Check All That Applies**

- Appendectomy
- Cholecystectomy (removal of gallbladder)
- Colon surgery? Why? \_\_\_\_\_
- Stomach surgery? Why? \_\_\_\_\_
- Colonoscopy: When and why?  
\_\_\_\_\_
- Upper Endoscopy: When and why?  
\_\_\_\_\_
- Hemorrhoidectomy
- Hysterectomy
- Prostatectomy
- Coronary artery bypass graft (heart bypass)
- Replacement of a heart valve
- Placement of a coronary stent
- Other surgery? Please explain:  
\_\_\_\_\_

## Are you allergic to any medication?

- No
- Yes. Please list:  
\_\_\_\_\_  
\_\_\_\_\_
- Latex Allergy? Please Circle: No Yes

**Please list all medications you are using, including over the counter medications:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Do you use any of the following medications?**

**Please check all that applies:**

- Coumadin/Warfarin
- Plavix
- Pradaxa
- Aspirin
- Lovenox
- Aggrenox

**Family History:**

**Please list any medical condition which may affect any of your first degree relatives:**

**Father:** \_\_\_\_\_

**Mother:** \_\_\_\_\_

**Brother:** \_\_\_\_\_

**Sister:** \_\_\_\_\_

**Son:** \_\_\_\_\_

**Daughter:** \_\_\_\_\_

**Is there family history of colon cancer?**

- No
- Yes. Who and at what age?  
\_\_\_\_\_

**Is there family history of colon polyps?**

- No
- Yes. Who and at what age?  
\_\_\_\_\_

**Do you smoke cigarettes?**

- No
- Yes. How many per day?  
\_\_\_\_\_

**Do you drink alcoholic beverages?**

- No
- Yes. How many drinks per week? -  
\_\_\_\_\_

**What is your weight?** \_\_\_\_\_

**What is your height?** \_\_\_\_\_

**What is the reason for your visit today? -**  
\_\_\_\_\_