Gastroenterology Specialists of Middle Tennessee
at TriStar Southern Hills
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Patient History

Please answer to the best of your ability, as this will help us to provide you with more efficient and complete healthcare

Name _____ Age _____ Today's date _____

Would you prefer that our staff call you by your:
[ ] first name [ ] last name [ ] something else

_____

Were you referred? [ ] No [ ] Yes - by whom?

_____

Please list all of your current physicians and their specialties:

_____

_____

__

What is the main reason for today's visit:

_____

Do you currently have or have you had in the past any medical problems?

[ ] Alcoholism	[ ] Diabetes	[ ] Seizures	[ ] Hepatitis
[ ] Anemia	[ ] Drug abuse	[ ] Sleep apnea	[ ] HIV/AIDS
[ ] Anorexia/bulimia	[ ] Emphysema	[ ] Stroke	[ ] H. pylori
[ ] Asthma	[ ] Heart disease	[ ] Thyroid disease	[ ] Irritable bowel syndrome
[ ] Blood dot in legs/lungs	[ ] Heart failure	[ ] Acid reflux/heartburn	[ ] Pancreatitis
[ ] Cancer	[ ] High blood pressure	[ ] Colon polyps	[ ] Ulcerative colitis
type _____	[ ] High cholesterol	[ ] Crohn's disease	[ ] Ulcers
[ ] Depression/anxiety	[ ] Kidney disease	[ ] Diverticular disease	

Any other problems not listed above? _____

_____

Have you undergone colonoscopy? [ ] No [ ] Yes

When _____

Where/by whom? _____

Have you undergone upper endoscopy? [ ] No [ ] Yes

When _____

Where/by whom? _____

Have you ever had surgery?

[ ] Appendix	[ ] Heart bypass	[ ] Hysterectomy	[ ] Pacemaker
[ ] Colon surgery	[ ] Heart stent	[ ] Kidney surgery	[ ] Spleenectomy
[ ] Gallbladder	[ ] Heart valve	[ ] Lap band	[ ] Stomach surgery
[ ] Gastric bypass	[ ] Hernia	[ ] Mastectomy	[ ] Tubal ligation

Any other surgery not listed above? _____

_____

Are you allergic to, or have you had a bad reaction to any medications? [ ] No [ ] Yes – please list

_____

_____

Are you are taking any blood thinners? [ ] No [ ] Yes – please list

_____

_____ Dr. who prescribes this medication _____

Please list all current medications (including OTC medication/supplements [ ] see attached list

_____

_____

_____

_____

Social History

[ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated [ ] Partner

Occupation: _____ [ ] Retired [ ] Disabled

Tobacco: [ ] smoke [ ] chew [ ] dip? [ ] No [ ] Yes – How much? _____

Alcohol: Drink [ ] beer [ ] wine [ ] liquor? [ ] No [ ] Yes – How much? _____

Do you use or have you in the past used drugs? [ ] No [ ] Yes – Specify _____

Family History

Has any close family member had any of the following?

	Who?		Who?
[ ] Colon polyps	_____	[ ] Crohn's disease	_____
[ ] Colon cancer	_____	[ ] Ulcerative colitis	_____
[ ] Esophageal cancer	_____	[ ] Gallbladder disease	_____
[ ] Pancreatic cancer	_____	[ ] Liver disease	_____
[ ] Stomach cancer	_____	[ ] Problems with anesthesia	_____
[ ] Alcoholism	_____	[ ] Problems with bleeding	_____

Are you currently experiencing any problems with (check any that apply):

[ ] Abdominal pain	[ ] Eye pain	[ ] Muscle pain
[ ] Nausea, vomiting	[ ] Vision	[ ] Joint pain
[ ] Increased gas	[ ] Mouth sores	[ ] Skin rash
[ ] Swallowing	[ ] Nosebleeds	[ ] Easy bruising
[ ] Heartburn	[ ] Hearing	[ ] Dizziness
[ ] Reflux	[ ] Sore throat	[ ] Headache
[ ] Diarrhea	[ ] Sinuses	[ ] Weakness
[ ] Constipation	[ ] Leg swelling	[ ] Anxiety
[ ] Rectal bleeding	[ ] Palpitations	[ ] Depression
[ ] Fecal incontinence	[ ] Chest pain	[ ] Stress
[ ] Black stool	[ ] Wheezing	[ ] Intolerance to cold
[ ] Greasy stool	[ ] Shortness of breath	[ ] Intolerance to heat
[ ] Jaundice	[ ] Cough	[ ] Unusual bleeding
[ ] Fever	[ ] Urinary burning	[ ] Enlarged lymph glands
[ ] Weight gain	[ ] Dark urine	<u>women</u>
[ ] Weight loss	[ ] Urine incontinence	[ ] Vaginal bleeding
[ ] Fatigue	[ ] Starting stream	Are you/could you be pregnant?
		[ ] No [ ] Yes
		[ ] last period _____ or [ ] menopause

When did you last have:

Blood test	_____	Upper GI X ray	_____
Abdominal ultrasound	_____	Barium enema	_____
Abdominal CT scan	_____		