Gastroenterology Specialists of Middle Tennessee
at TriStar StoneCrest
Patient History

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Name_____ **Date of Birth**_____ **Date**_____

Name of physician who referred you_____

Please list all of your current physicians and their specialties_____

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 clot in legs/lungs	◯ Heart Failure	◯ Acid Reflux/heartburn	◯ Pancreatitis
◯ High blood pressure	◯ Colon polyps	◯ Ulcerative colitis	◯ High cholesterol	◯ Crohn's Disease
◯ Ulcers	◯ Depression/Anxiety	◯ Kidney Disease	◯ Diverticular Disease	
◯ Cancer (Type_____)				

Any other problems no listed above?_____

Have you undergone a colonoscopy? ◯ No ◯ Yes When?_____ Where?_____

By Whom?_____

Have you undergone an upper endoscopy? ◯ No ◯ Yes When?_____ Where?_____

By Whom?_____

Have you ever had surgery?

◯ Appendix	◯ Heart Bypass	◯ Hysterectomy	◯ Pacemaker	◯ Colon Surgery
◯ Heart stent	◯ Kidney surgery	◯ Splenectomy	◯ Gallbladder	◯ Heart valve
◯ Lap band	◯ Stomach surgery	◯ Gastric bypass	◯ Hernia	◯ Mastectomy
◯ Tubal ligation				

Any other surgeries not listed above?_____

Are you taking any blood thinners? ◯ No ◯ Yes – Please list medication and name of physician who prescribes it

_____

Please list all other medications (including over-the-counter medications/supplements) ◯ See Attached List

_____

_____

_____

_____

Are you allergic to, or have you had a bad reaction to any medications? ◯ No ◯Yes – Please list

_____

When did you last have?

Blood Test_____ Upper GI x-ray_____ Barium enema_____

Abdominal Ultrasound_____ Abdominal CT Scan_____

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_____
○ Currently? ○ In past?

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	
◯ Uterine Cancer		◯ Problems with bleeding	
◯ Ovarian Cancer		◯ Alcoholism	

Are you currently experiencing concerns with any of the following? (check any that apply)

◯ Abdominal pain	◯ Mouth sores	◯ Dizziness	◯ Nausea, vomiting	◯ Nosebleeds
◯ Headache	◯ Increased gas	◯ Hearing	◯ Weakness	◯ Swallowing
◯ Sore throat	◯ Anxiety	◯ Heartburn	◯ Sinuses	◯ Depression
◯ Reflux	◯ Leg swelling	◯ Stress	◯ Diarrhea	◯ Palpitations
◯ Constipation	◯ Chest pain	◯ Rectal Bleeding	◯ Wheezing	◯ Fecal Incontinence
◯ Shortness of breath	◯ Black stool	◯ Cough	◯ Greasy stool	◯ Urinary burning
◯ Jaundice	◯ Dark urine	◯ Fever	◯ Urine incontinence	◯ Intolerance to cold
◯ Intolerance to heat	◯ Enlarged lymph glands	◯ Milk Products	◯ Weight Gain	◯ Weight Loss
◯ Starting Stream	◯ Muscle pain	◯ Fatigue	◯ Joint pain	◯ Eye pain
◯ Skin rash	◯ Vision	◯ Easy Bruising	◯ Environmental allergies	

Women:

◯ Vaginal bleeding

Are you/could you be pregnant? ◯ No ◯ Yes

◯ Last Period_____ or ◯ Hysterectomy ◯ Menopause