

JOHN B. STURGEON, M.D.

INTERNAL MEDICINE & GASTROENTEROLOGY

CONSERVATIVE SOLUTIONS, COMPASSIONATE CARE

New Patient Information

Please complete and bring with you to your appointment

Date _____

I. Name: _____
(Last) (First) (MI)

Age: _____ Date of Birth: _____/_____/_____ Sex: Male/Female SSN: _____/_____/_____

Primary Care Physician: _____

II. **Chief Complaint:** Briefly state the main problem you are experiencing at this time:

III. **History of Present Illness:**

When did the symptoms begin? Date: _____

What improves the symptoms? _____

What worsens the symptoms? _____

What remedies have you tried? _____

If the main symptom is pain, how would you characterize it? (dull, sharp, crampy, aching, other): _____

How frequently does it occur? _____

Gradual or sudden onset? _____

Constant or intermittent? _____

How long does it last? _____

Where is it located? (Please Circle): -Chest -Abdomen, right upper, left upper, right lower, left lower, mild

Does it radiate anywhere? (i.e. back, shoulder) Y / N If Yes Where: _____

Do you have any of the following symptoms? If yes please describe.

Difficulty swallowing? Y / N _____

Heartburn? Y / N _____

Chest pain with swallowing? Y / N _____

Regurgitation of food/fluid to the throat? Y / N _____

Coughing at night? Y / N _____

Chronic hoarseness/Laryngitis? Y / N _____

Constipation? Y / N _____

Blood in stool? Y / N _____

Black, tarry stool? Y / N _____

Weight loss? Y / N (If yes, how much and over what period of time?) _____

Change in bowel habits? Y / N _____

IV. **Past Medical History**

A. Gastrointestinal Disease

1. Have you been diagnosed with any of the following gastrointestinal or liver diseases? Please circle.

Achalasia, gastroesophageal reflux, esophagitis, esophageal stricture, Barrett's esophagus, hiatal hernia, gastric ulcer, duodenal ulcer, gastritis, Crohn's disease, gallstones, hepatitis (A, B, C, autoimmune, other), sclerosing cholangitis, primary biliary cirrhosis, jaundice, cirrhosis (any type), bowel obstruction, acute or chronic pancreatitis, ulcerative colitis, diverticulitis, diverticulosis, irritable bowel syndrome, colon polyps, hemorrhoids, anal fissure.

(over)

2. Have you been diagnosed with any gastrointestinal cancer? Y / N If yes please circle: (esophagus, stomach, small intestine, liver, pancreas, gallbladder, bile ducts, colon, rectum, anus)

Comments: (please explain anything circled above, if necessary) _____

B. Have you had any previous gastrointestinal procedures? Y / N endoscopy, colonoscopy, ERCP, upper GI, small bowel follow through, barium enema) If yes, When, result? _____

C. General Medical History

Do you have a history of any illness/conditions? (Mark all that apply)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Addison's Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Allergies/Hayfever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Prostate Enlargement |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthetic Heart Valve |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Meniere's Disease | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mumps | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Muscular Diseases | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Blood Diseases | <input type="checkbox"/> Headache | <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Hearing Loss/Deafness | <input type="checkbox"/> Ovarian Cyst | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Heart Attack (M.I.) | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Breast Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Herpes (Genital) | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tubal Pregnancy |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Pericarditis | <input type="checkbox"/> Ureteral Stents |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Urinary Tract Infections |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Uterine Cancer |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Coronary Stents | <input type="checkbox"/> Kidney Infections | <input type="checkbox"/> Polio | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Cushings | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Pregnancy | |

D. Past Surgical History (list all operations/procedures)

Date	Operation
_____	_____
_____	_____
_____	_____
_____	_____

V. Current Medications (if more meds taken, please attach list)

Medication	Date	Frequency	Duration
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you use over-the-counter medications/supplements? Y / N (if yes please list)

VI. Allergies No known drug allergies

Medication

Reaction

_____	_____
_____	_____
_____	_____

VII. Family History

Do any family members have a history of gastrointestinal or liver disease (including cancer) listed in section IV-A? Y / N
(If yes, describe relative and disease) _____

Is there a family history of breast, uterine or cervical cancer? Y / N

Please list any chronic illness/cause of death of the following relatives:

Mother _____

Father _____

Siblings _____

Children _____

Grandparents _____

VIII. Social History

Do you use tobacco products? Y / N (If yes, what type, how often, and for how long?) _____

Do you use alcohol? Y / N (If yes, what type, how often, and for how long?) _____

Are you working outside the home? Y / N (If yes, occupation) _____

Marital Status: Single Married Divorced

IX. Review of Systems (Check those which have occurred recently.)

General

- ___ Weight gain
- ___ Weight loss
- ___ Weakness
- ___ Fatigue
- ___ Fever
- ___ Chills
- ___ Night sweats

Skin

- ___ Color changes
- ___ Nail changes
- ___ Hair changes
- ___ Mole changes
- ___ Rashes
- ___ Itching
- ___ Sores
- ___ Dryness

Head

- ___ Headaches
- ___ Injuries
- ___ Glasses
- ___ Contacts

Eyes

- ___ Blurred vision
- ___ Cataracts
- ___ Glaucoma
- ___ Redness/Itching
- ___ Burning
- ___ Swelling
- ___ Pain
- ___ Dryness
- ___ Tearing

Ears

- ___ Hard of hearing
- ___ Deafness
- ___ Ringing
- ___ Discharge
- ___ Ear Ache
- ___ Itching
- ___ Loss of balance
- ___ Dizziness
- ___ Room spins

(over)

Nose	Mouth	Throat	Neck	Breasts
<input type="checkbox"/> Decreased smell	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Soreness	<input type="checkbox"/> Enlargement	<input type="checkbox"/> Discharge
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Sores	<input type="checkbox"/> "Bad" tonsils	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Lumps
<input type="checkbox"/> Pain	<input type="checkbox"/> Dental problem	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Lumps	<input type="checkbox"/> Pain
<input type="checkbox"/> Discharge	<input type="checkbox"/> Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Masses	<input type="checkbox"/> Bleeding
<input type="checkbox"/> Obstruction	<input type="checkbox"/> Bad breath	<input type="checkbox"/> Trouble swallowing		<input type="checkbox"/> Nipple changes
<input type="checkbox"/> Post nasal drip	<input type="checkbox"/> Loss of taste	<input type="checkbox"/> Recurrent infections		<input type="checkbox"/> Skin changes
<input type="checkbox"/> Deviated septum	<input type="checkbox"/> Dry mouth			<input type="checkbox"/> Fullness
<input type="checkbox"/> "Runny" nose	<input type="checkbox"/> Ulcers			
<input type="checkbox"/> Sinus congestion	<input type="checkbox"/> Blisters			

Lungs	Heart	Blood	Gastrointestinal	Gastrointestinal
<input type="checkbox"/> Cough	<input type="checkbox"/> Murmur	<input type="checkbox"/> Anemia	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Constipation
<input type="checkbox"/> Phlegm	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Low Blood Iron	<input type="checkbox"/> Nausea	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Blood in sputum	<input type="checkbox"/> Rapid heart beat	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Gas
<input type="checkbox"/> Short of breath	<input type="checkbox"/> Cold extremities	<input type="checkbox"/> Easy bleeding	<input type="checkbox"/> Bloating	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Swollen nodes	<input type="checkbox"/> Belching	<input type="checkbox"/> Hernia
<input type="checkbox"/> Pain	<input type="checkbox"/> Chest pressure	<input type="checkbox"/> Painful nodes	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Poor appetite
<input type="checkbox"/> Congestion	<input type="checkbox"/> Varicose veins		<input type="checkbox"/> Indigestion	<input type="checkbox"/> Food intolerance
<input type="checkbox"/> Inhalant exposure	<input type="checkbox"/> Blood clots		<input type="checkbox"/> Irregular bowel habits	<input type="checkbox"/> Bloody stools
	<input type="checkbox"/> Blue extremities			<input type="checkbox"/> Black stools

Genitourinary	Genitourinary	Gynecological	Gynecological	Gynecological
<input type="checkbox"/> Urgency	<input type="checkbox"/> Bloody urine	<input type="checkbox"/> Spotting	<input type="checkbox"/> Age at 1st period	<input type="checkbox"/> Menstrual flow
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Small stream	<input type="checkbox"/> Menstrual cramps	<input type="checkbox"/> Age at menopause	<input type="checkbox"/> (Heavy, Mod, Light)
<input type="checkbox"/> Straining	<input type="checkbox"/> Discharge	<input type="checkbox"/> Discharge	<input type="checkbox"/> Duration of cycle	<input type="checkbox"/> ___/___/___ LMP
<input type="checkbox"/> Back pain	<input type="checkbox"/> Sores	<input type="checkbox"/> Itching	<input type="checkbox"/> Duration of flow	
<input type="checkbox"/> Frequent voiding	<input type="checkbox"/> Impotence	<input type="checkbox"/> Painful intercourse	<input type="checkbox"/> # of pregnancies	
<input type="checkbox"/> Stones	<input type="checkbox"/> Dribbling	<input type="checkbox"/> Irregular periods	<input type="checkbox"/> # of Births	
<input type="checkbox"/> Burning	<input type="checkbox"/> Cloudy urine	<input type="checkbox"/> Hot flashes	<input type="checkbox"/> # of miscarriages	
<input type="checkbox"/> Bed wetting		<input type="checkbox"/> Contraception	<input type="checkbox"/> # of abortions	

Musculoskeletal	Neurological	Psychiatric	Endocrine
<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Seizures	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Heat intolerance
<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Depression	<input type="checkbox"/> Cold intolerance
<input type="checkbox"/> Muscle cramps	<input type="checkbox"/> Sensory loss	<input type="checkbox"/> Irritability	<input type="checkbox"/> Voice changes
<input type="checkbox"/> Joint pain/swelling	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Extreme thirst
<input type="checkbox"/> Back pain	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Drug dependency	<input type="checkbox"/> Breast changes
<input type="checkbox"/> Other	<input type="checkbox"/> Numbness	<input type="checkbox"/> Suicidal tendency	

Thank you for completing this history which will become part of the permanent record.

Completed by: _____ Relationship to patient: _____ Date: _____

(For Office Use Only)

X. History Update	Reviewed by: _____	Date: _____	Initials: _____
	Reviewed by: _____	Date: _____	Initials: _____
	Reviewed by: _____	Date: _____	Initials: _____