East Carolina Gastroenterology PA
East Carolina Gastroenterology Endoscopy Center

Date of this visit: _____

Demographic Information

Last name: _____ First name: _____ MI: _____

Address (Street, City, Zip code): _____

Date of Birth:_____ Age: _____ Sex: M F Marital Status: S M D W # of children: ____

How did you find us? ◯ Friend/Family ◯Phone Book ◯Referred by doctor ◯Online

Primary Care Physician: _____ Referring Physician: _____

Social Security #: _____ Occupation: _____

Home phone: _____Work phone: _____ Cell phone: _____

Please circle which telephone number you prefer to receive appointment reminder phone calls.

Spouse/Sponsor Name: _____ DOB: _____ SSN: _____

Emergency Contact Name & Phone #: _____

Preferred Pharmacy: _____ Preferred Email: _____

Please provide us with a personal (not work related) e-mail address, and you will be able to access your personal health records, **RECEIVE LAB/PATHOLOGY RESULTS**, request medication refills, receive educational material, view your statements, send to and receive messages from our clinical staff. These benefits are available through our secure patient portal which you can access from your smart phone or computer. **IT IS VERY IMPORTANT THAT YOU IMMEDIATELY ACCESS AND COMPLETE THE SIGN-ON PROCESS.**

Reason For Visit(by patient): _____
Physician notes:_____
_____
_____
_____

Past Medical History (check all that apply):

◯ Ulcerative colitis	◯ Hepatitis A/B/C	◯ Colon Cancer	◯ Crohn's Disease	◯ Colon Polyps
◯ Irritable bowel syndrome	◯ Blood in stool	◯ Pancreatic disease	◯ Diabetes	◯ Stroke
◯ Stomach (gastric) ulcers	◯ Asthma	◯ Heart attack	◯ Heart failure	◯ Anemia
◯ Bronchitis (COPD)	◯ Acid reflux	◯ High cholesterol	◯ Sleep apnea	◯ Seizures/epilepsy
◯ High blood pressure	◯ Depression	◯ Bleeding problems	◯ Blood transfusions	

Other medical history: _____

Past Surgeries: _____
_____
_____

Previous tests/surgeries (when and where):

◯ Upper endoscopy	◯ Colonoscopy	◯ CT scan	◯ Barium enema
◯ Upper GI X-ray	◯ Gallbladder ultrasound	◯ Barium swallow	◯ Pacemaker/Defibrillator

Medications

Name	Dosage	Frequency

Name	Dose	Frequency

Other current medications and doses (include over the counter & herbal medications): _____

_____

Social History

Alcohol: Y N Tobacco use: Current Former Never Recreational Drug Use: Y N

Daily use of NSAIDs (ex aspirin, Aleve, Motrin, Ibuprofen, Goody Powder, etc): Y N

Allergies to medications, foods, or latex (list name and type of reaction):_____

_____

Family History (check all that apply)

	Colon Cancer	Colon Polyps	Stomach Cancer	Uterine Cancer	Genital/Urinary Cancer	Ulcerative Colitis	Crohn's Disease	Liver Disease
Father								
Mother								
Siblings								
Child								
Grandparents								

Review of Systems (Please check the circle if you currently have any of these symptoms)

General	○ Weight loss	○ Loss of appetite	○ Fatigue
Gastrointestinal	○ Blood in stool ○ Difficulty swalling ○ Heartburn	○ Constipation ○ Change in bowel habit ○ Nausea/vomiting	○ Diarrhea ○ Painful defecation ○ Abdominal pain
Cardiology	○ Shortness of breath ○ Palpitation	○ Dizziness ○ Swollen ankles	○ Chest pain
ENT/Respiratory	○ Hearing loss ○ Frequent sore throat	○ Nose bleeds ○ Hoarseness	○ Ear pain ○ Chronic cough
Genitourinary	○ Difficulty urinating ○ Decreased force in urinating ○ Heavy periods	○ Painful urination ○ Incontinence of urine	○ Blood in urine ○ History of kidney stones
Neurology	○ Frequent headaches ○ Dizziness	○ Glaucoma ○ Failing vision	○ Cataracts ○ Seizures
Psychiatry	○ Nervousness/anxiety ○ Memory loss	○ Depression ○ Sleeping difficulty	○ Moodiness
Musculoskeletal	○ Recurrent low back pain	○ Arthritis	○ Numbness/tingling hands/feet

I give permission to East Carolina Gastro to discuss my medical history with anyone that provide this PERSONAL PASSWORD_____. I am responsible for giving this password to anyone that I wish to have access to my medical information.

Patient Signature: _____ Date: _____