Bhatti GI Consultants, P.A.

New Patient HEALTH HISTORY

Patient to Complete and Bring in at Appointment
(pages 1 of 3)

Dear Patient: Thank you for taking the time to complete this form prior to your appointment. PLEASE PRINT and fill out to the best of your ability. Spelling is NOT important. If you have trouble with any section, leave it blank, and the doctor or nurse can go over that area with you.

Please arrive 20 minutes early for your appointment. If you need assistance with the entire form, inform the receptionist, and one of our staff persons will assist you.

NAME _____

Date of Birth _____ Age _____Today's Date _____

Current Primary Care Physician _____
Physician who referred you to us _____
Symptoms or reason for this visit _____
When did your symptom or symptoms first begin? _____
How often do your symptoms occur? _____
Is there anything that gives relief (i.e., change in position, resting, etc.?)
_____
Have you had any test (blood work, x-rays, etc.) pertaining to the reason for this visit? ___yes ___no
If so, when and where were they done?
_____
Female patients: Date of your last pelvic examination _____

CHECK ANY GI SYMPTOMS WHICH YOU MAY HAVE:

- ☐ Difficulty or painful swallowing (food or liquids become stuck)
- ☐ Heartburn/indigestion
- ☐ Gaseousness/bloating
- ☐ Distress from spicy or fatty foods
- ☐ Vomiting/Nausea Pain in abdomen
- ☐ Jaundice (yellow eyes/skin)
- ☐ Black or bloody stools
- ☐ Rectal bleeding
- ☐ Light colored stool
- ☐ Constipation Change in bowel habits
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Eating disorder Special Diet: (type) _____

In the past 12 months, have you experienced abdominal discomfort or pain for at least 12 or more weeks total (doesn't need to be continuous) yes/no (please circle).
If you circled yes, was the discomfort or pain relieved when you have a bowel movement? (yes/no)
When it began, did you have a change in the frequency of stool? (yes/no)
When it began, was there a change in the form (appearance) of the stool? (yes/no)

YOUR PERSONAL HEALTH HISTORY

Surgeries: Type of Operation, Where & What Year
_____ _____

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Medical History: Major or Chronic Illness & Date of Onset

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

YOUR FAMILY'S HEALTH HISTORY

(Enter which family member. If family member is deceased, at what age did they die?)
Colon or rectal cancer _____ Stomach Ulcer_____
Colon Polyps _____ Liver disease _____
Crohn's disease _____ Gallbladder disease _____
Ulcerative colitis _____ Other cancers _____

YOUR SOCIAL HISTORY
Your employment _____ Single/Married/Divorced (circle)
Who lives with you now? _____
Do you have children: _____Ages:_____
Smoking history (packs/day and # of years) _____
Milk Intake: _____
Exposure to toxic chemicals: _____
Exposure to Hepatitis C: _____
Vietnam Veteran: (yes/no)
Tattoos or body piercings: (yes/no)
Have you ever used/experimented with I.V. drugs or "sniffing" drugs? (yes/no)
When: _____
Current alcohol intake (amount, how often) _____
Past alcohol intake (amount, how often) _____
Have you traveled outside the U.S?: (when/where)
_____
History of Blood Transfusion or blood products: _____
When: _____

Please circle if these symptoms are present:

General Fever or chills, sweats, fatigue, weakness, lack of energy, bleeding tendency, weight gain or loss
Eyes, ears, nose, throat Eye problems, ear problems, hoarseness, sore throat, sinus problems, mouth sores
Skin Rash, flaking, itching
Heart Chest pain, high BP, murmur, dizziness, fainting, ankle/leg swelling, poor circulation, palpitations
Lungs Chronic cough, shortness of breath, spitting blood, asthma, bronchitis, emphysema
Endocrine Diabetes, thyroid disease, thirst
Genitourinary Frequent urination, painful urination, urgent urination, blood in urine, dark urine, venereal disease
Joints Back pain, arthritis, joint or muscle pains
Neurological- Severe headaches, poor sleep, sadness/depression, crying spells, nervousness, seizures
Psychiatric
Allergy/immune Immune deficiency, hay fever
Explain any of the above if needed
_____
_____
_____

_____
_____

_____ _____
(Patient/Guardian Signature/Date) **(Reviewing Physician Signature/Date)**

Allergies Reaction

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies to Latex? Yes/No If Yes, please describe:_____

Current Medications

(Including over-the-counter medicines such as aspirin, Tylenol, vitamins, herbs, supplements, etc.)
Name Reason Dose/How often

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Pharmacy Name/Location/Phone #: _____