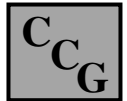


# Central Coast Gastroenterology Medical Group



Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Steven W. Carlson, M.D.  
 Gary L. Cushing, M.D.  
 Jeffrey B. Mundorf, M.D.  
 Mick S. Meiselman, MD

Vance D. Rodgers, M.D.  
 Paul D. Wetzel, M.D.  
 Jonathan L. Riegler, M.D.

## What brings you into the office today?

Problem	Date of Onset

## CURRENT MEDICATIONS

Name of Medicine	Strength of Each Dose	How Often Taken	When Began Taking

## Are you allergic to any medications?

medication	reaction	medication	reaction

## FAMILY HEALTH

\*Do you have any blood relative with a history of colon cancer? ( )yes ( )no if yes, who\_\_\_\_\_

Relation	Age	Still alive?	State of Health or Cause of Death	History of colon cancer or colon polyps?
Mother		( ) yes ( ) no		( ) yes( ) no if yes, age at diagnosis____
Father		( ) yes ( ) no		( ) yes( ) no if yes, age at diagnosis____
Brothers and Sisters		( ) yes ( ) no		( ) yes( ) no if yes, age at diagnosis____
		( ) yes ( ) no		( ) yes( ) no if yes, age at diagnosis____
		( ) yes ( ) no		( ) yes( ) no if yes, age at diagnosis____
Grandparents		( ) yes ( ) no		( ) yes( ) no if yes, age at diagnosis____
		( ) yes ( ) no		( ) yes( ) no if yes, age at diagnosis____
		( ) yes ( ) no		( ) yes( ) no if yes, age at diagnosis____
		( ) yes ( ) no		( ) yes( ) no if yes, age at diagnosis____

## SURGICAL HISTORY

Operation	Hospital and City	Date

\*\* Please fill out both sides of this form\*\*

Reviewed by \_\_\_\_\_

Name \_\_\_\_\_

Today's Date: \_\_\_\_\_

**MEDICAL HISTORY**

	Yes	No		Yes	No		Yes	No
angina			glaucoma			murmur		
anxiety			heart attack			palpitations		
arthritis			hepatitis			parkinson's disease		
asthma			high blood pressure			peptic ulcer disease		
cataract extraction			high cholesterol			prostate cancer		
<b>Have you ever had colon cancer?</b>			insomnia			prostate enlargement		
<b>colon polyps</b>			jaundice			seizures		
COPD/chronic bronchitis			kidney disease or kidney stones			sleep apnea		
depression			lupus			stroke		
diabetes			melanoma			thyroid disease		
emphysema			menopause			TIA		
endometriosis			migraine headaches			trouble breathing		
fibromyalgia			Do you require antibiotic prophylaxis before medical procedures?			Would you accept blood products if needed?		
gallbladder disease/gallstones								
Are you currently pregnant?			<b>Have you ever had the Pneumonia Vaccine?</b>			Hepatitis A, B, C, D or E? (circle one)		
<b>Do you smoke?</b> (circle one) Daily/ Some days/ Former Smoker/Never Smoked			Do you drink alcohol? Yes or No If so, how much do you drink? ____/day/wk/month					

**Do you have any of the following symptoms?**

	yes	no
nausea or vomiting		
diarrhea		
constipation		
blood in your stools or rectal bleeding		
heartburn		
fever or chills		
easy fatigability		
headaches		

	yes	no
chest pain		
palpitations		
numbness, weakness, or tingling		
painful urination or blood in the urine		
back pain		
joint pain		
rash or itching		
visual changes		

	yes	no
hearing loss		
oral problems		
cough or wheezing		
intolerance to heat or cold		
weight gain		
weight loss		
hair loss		
easy bleeding or bruising		

**SCREENING EXAMS**

<i>Please list the results of the following tests:</i>	<i>Date done</i>	<i>Where were these performed?</i>
BLOOD TESTS		
HEMOCCULT OF STOOLS (Tests for Blood in Stool)		
SIGMOIDOSCOPY		
COLONOSCOPY		

**X-RAY EXAMS**

<i>Please list the results of the <b>most recent</b> following tests and where they were performed:</i>	<i>Date performed</i>
UPPER GI SERIES (Stomach X-Rays)	
LOWER GI SERIES (Barium Enema)	
ULTRASOUND OF ABDOMEN	
CAT SCAN OF ABDOMEN	

Reviewed by \_\_\_\_\_