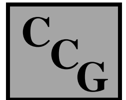
Central Coast Gastroenterology Medical Group



Name: ______________________________
DOB: ______________ Today's Date: ______________

Neal A. Moller, M.D.
Jeffry A. Brown, M.D.
Jeffrey B. Mundorf, M.D
Mick S. Meiselman, MD
Vance D. Rodgers, M.D.
J. Carlos Hernandez, 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___
		( ) 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		
Have you ever had colon cancer?			insomnia			prostate enlargement		
colon polyps			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?			**Have you ever had the Pneumonia Vaccine?**			Hepatitis A, B, C, D or E? (circle one)		
Do you smoke? (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		yes	no		yes	no
nausea or vomiting			chest pain			hearing loss		
diarrhea			palpitations			oral problems		
constipation			numbness, weakness, or tingling			cough or wheezing		
blood in your stools or rectal bleeding			painful urination or blood in the urine			intolerance to heat or cold		
heartburn			back pain			weight gain		
fever or chills			joint pain			weight loss		
easy fatigability			rash or itching			hair loss		
headaches			visual changes			easy bleeding or bruising		

SCREENING EXAMS

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

X-RAY EXAMS

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

Reviewed by ______________