ELMS DIGESTIVE

Judd B. Adelman, MD • David A. Florez, MD • Gregory C. Goodear, MD • Todd L. Snyder, MD

Thank you for choosing Elms Digestive for your care today.
We are committed to providing the highest quality of medical care for each of our patients.

Please complete all sections of this medical history questionnaire. These questions are designed to provide our physicians with crucial information to optimize your visit today. If you are uncertain about any section of the form, mark the section with a (?) and your nurse will review it with you. Thank you again for choosing Elms Digestive.

Name:	☐ Male ☐ Female	Height: Weight:

Doctor You are Seeing Today (Circle One):	Primary Care Physician:
Adelman Florez Goodear Snyder	Pharmacy:

Please *briefly explain why* you are being seen today at Elms Digestive:

Are you currently experiencing any of the follow symptoms:

☐ Acid Reflux	☐ Bloody Stools or Black Stools	☐ Bloating	☐ Regurgitation
☐ Abdominal Pain	☐ Chronic Cough	☐ Constipation	☐ Change in bowel habits
☐ Change in Voice	☐ Epigastric Pain	☐ Heartburn	☐ Diarrhea
☐ Difficulty Swallowing	☐ Nausea	☐ Vomiting	☐ Hoarseness
☐ Sore Throat	☐Weight Gain	☐ Yellowing of the skin	☐ Vomiting Blood
☐ Weight Loss			

Have you ***recently*** undergone an X-Ray, CT, MRI, or any other radiologic test? ☐ **Yes** ☐ **No**

If you answered ***Yes*, Date of Test:_____ Location:_____

Have you ***recently*** had your blood drawn? ☐ **Yes** ☐ **No**

If you answered ***Yes*, Date:_____ Location:_____

Have you ***recently*** been hospitalized because of the problems you are being seen for today? ☐ **Yes** ☐ **No**

If you answered ***Yes*, Date:_____ Hospital:_____

Colonoscopy and Upper Endoscopy History

Complete if you have had a Colonoscopy or Upper Endoscopy (EGD) in the past

Colonoscopy: Year	Polyps?	Location	Physician
Upper Endoscopy (EGD): Year		Location	Physician

continued on back

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Medications

List your Prescribed Drugs and Over-The-Counter Drugs (include -vitamins and supplements)

Name of medication and ***Why*** the medication was prescribed	Dose/Strength	Frequency (Daily, twice a day, at bedtime, etc.)

Are you ***currently*** taking any of the following ***blood thinning*** medications:

☐ Aspirin ☐ Clopedogrel (Plavix) ☐ Warfarin (Coumadin) ☐ Heparin ☐ Xarelto ☐ Pradaxa ☐ Eliquis

Allergies

*If you answer Yes to any of the following, please specify
what reaction you had to the allergen in the space provided (**rash, hives, difficulties breathing, etc.**)

☐ Shellfish: _____
☐ Nuts: _____
☐ Eggs: _____
☐ Soy: _____
☐ Wheat: _____

☐ Latex: _____
☐ Iodine: _____
☐ Sulfa Drugs: _____
☐ Penicillin: _____
☐ Codeine: _____

List Any Additional Allergies:

☐ **I do not have allergies to any medications.**

Surgeries and Hospitalizations

Year	Name of Hospital	Surgery or Reason for Hospitalization

Have you ever had complications with Anesthesia? ☐ **Yes** ☐ **No**
If you answered ***Yes***, please briefly explain complication:

Family Health History

Indicate if any of your family members listed below have been diagnosed with the following:

	Mother	Father	Sister	Brother	Grandmother	Grandfather	Aunt/Uncle	Son	Daughter
Colon or Rectal Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stomach Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Esophageal/Throat Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐

☐ I do not have a family history of GI related cancers.

Social History

Are you currently, or have you in the past used any of the following substances:

☐ Caffeine (# of drinks per day) _____ ☐ Tobacco (# of packs per day) _____ ○ Previously or ○ Currently

☐ Alcohol (# of drinks per day) _____ ☐ Illegal/Recreational Drug Use (name of drug) _____

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Have you been diagnosed and/or treated in the past or are currently being treated for the following diseases or disorders:

Cardiovascular

☐ Abnormal Heart Rate/Rhythm ☐ Angina (Chest Pain) ☐ Congestive Heart Failure ☐ Coronary Artery Disease
☐ Edema (Swelling) ☐ Heart Murmur ☐ Heart Stent Date:_____ ☐ History of Blood Clots
☐ High Blood Pressure ☐ High Cholesterol ☐ History of Heart Attack Location:_____
☐ Peripheral Artery Disease ☐ **Other:** Date:_____ ☐ Pacemaker Date:_____

Eyes, Ears, Nose and Throat

☐ Allergic Rhinitis ☐ Cataracts ☐ Double or Blurred Vision ☐ Glasses/Contacts
☐ Sore Throat ☐ Chronic Nose Bleeds ☐ Chronic Sinus Infections ☐ **Other:**

Endocrine

☐ Diabetes Mellitus Type I ☐ Hormone Replacement Therapy ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Osteoporosis
☐ Diabetes Mellitus Type II

Genitourinary

☐ Bladder Cancer ☐ Blood in Urine ☐ Dialysis ☐ Kidney Disease ☐ Kidney Stones
☐ Pain on Urination ☐ Prostate Problems ☐ Renal Failure ☐ Urinary Incontinence ☐ **Other:**

Hematologic/Immunologic/Lymphatic

☐ Anemia ☐ Bleeding Disorder ☐ Easy Bruising ☐ HIV /AIDS ☐ HIV Exposure ☐ Immune Deficiency
☐ Hodgkin's Lymphoma ☐ Non-Hodgkin's Lymphoma ☐ Lupus ☐ Rheumatoid Arthritis ☐ Tuberculosis ☐ **Other:**

Musculoskeletal

☐ Arthritis ☐ Back Pain ☐ Muscle Weakness ☐ Restless Leg Syndrome ☐ Weak Grip ☐ **Other:**

Neurologic

☐ Alzheimer's Disease ☐ Brain Tumor ☐ Dementia ☐ Epilepsy ☐ History of Aneurysm ☐ History of Stroke
☐ Parkinson's Disease ☐ Vertigo ☐ **Other:** Date:_____

Psychiatric

☐ Anxiety ☐ Bipolar ☐ Depression ☐ Hallucinations ☐ Paranoia ☐ Post-Traumatic Stress Syndrome
☐ Panic Attacks ☐ Suicidal Thoughts ☐ **Other:**

Skin

☐ Acne ☐ Dermatitis ☐ Eczema ☐ Psoriasis ☐ Warts ☐ **Other:**

Respiratory

☐ Asthma ☐ COPD ☐ Chronic Bronchitis ☐ Emphysema ☐ Lung Cancer ☐ Sleep Apnea
☐ History of Pulmonary Embolism ☐ Using Oxygen At Night:____ 24hrs/day____ ☐ **Other:** CPAP:_____

Digestive

☐ Anal Fissures ☐ Acid Reflux ☐ Appendix Problems ☐ Barrett's Esophagus ☐ Bowel Obstruction
☐ Colitis (Inflammation of the Colon) ☐ Clostridium Difficile ☐ Celiac Disease ☐ Colon Cancer ☐ Colon Polyps
☐ Crohn's Disease ☐ Diverticulosis/ Diverticulitis ☐ Dysphagia (Difficulty Swallowing) ☐ Esophagus/Throat Cancer ☐ Gallbladder Problems
☐ Gastritis (Inflammation of the Stomach) ☐ Gallstones ☐ Gastroesophageal Reflux Disease (GERD) ☐ Helicobacter Pylori (H Pylori) ☐ Hemorrhoids
☐ Hepatitis A, B, C (Circle One) ☐ Hiatal Hernia ☐ Irritable Bowel Syndrome ☐ Jaundice (Yellowing of the Skin) ☐ Liver Problems
☐ Fatty Liver ☐ Liver Cancer ☐ Pancreas Problems ☐ Pancreatic Cancer ☐ Stomach Ulcers
☐ Ulcerative Colitis ☐ **Other:**