mana
medical associates

# MANA Gastroenterology

## Patient History

fdc
fayetteville diagnostic clinic, ltd.
A MANA Clinic

## General

Name ______________________________ Date ____________

DOB ____________ Age ______

Referring Physician ______________________________

**Current gastrointestinal problems/reason for visit** ______________________________

______________________________

______________________________

______________________________

**Past medical problems** ______________________________

______________________________

______________________________

______________________________

**Date of last colon exam** ______________________________

**Any history of hypertension, diabetes, heart disease, kidney disease, arthritis, lupus?** ______________

## For Hepatitis Patients:

*Please check all that apply*

- ❏ Blood transfusion prior to 1992?
- ❏ Tattoos?
- ❏ Ever had abnormal liver enzymes prior to being told you had hepatitis?
- ❏ Ever donated blood? If yes, when ______________________________
- ❏ Did the blood bank inform you of abnormal lab?
- ❏ Ever used IV drugs or cocaine? If yes, when used last ______________________________

## Past Surgical History:

| *Operation* | *Where and When* |
|---|---|
| ____________________ | ____________________ |
| ____________________ | ____________________ |
| ____________________ | ____________________ |
| ____________________ | ____________________ |

## Current Medications: *List all medications you currently take. Please include over the counter medications.*

______________________________

______________________________

______________________________

______________________________

***- next page -***

**Allergies:** *List any drugs you cannot take.*

______________________________________________

______________________________________________

______________________________________________

______________________________________________

## Family Health History:

*Medical Condition(s)*

Mother ______________________________________________

Father ______________________________________________

Brother(s) ______________________________________________

Sister(s) ______________________________________________

Children ______________________________________________

Anyone in the family with liver disease, colon polyps, colon cancer, pancreatic cancer, stomach cancer, sprue, Crohn's disease, or ulcerative colitis?

______________________________________________

______________________________________________

______________________________________________

## Social History:

Marital status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Number of Children and Ages ______________________________________________

Occupation ______________________________________________

## Habits:

Tobacco use? ❑ Yes ❑ No If yes, how much? ______________________________________________

Alcohol use? ❑ Yes ❑ No If yes, approximately how much do you drink?______________________________________________

Recreational or illicit drug use? ❑ Yes ❑ No Which substance(s)? ______________________________________________

## Gastrointestinal Review:

*Have you had or do you have any of the following? If yes, please indicate when in the space provide below.*

❑ Jaundice

❑ Ulcers

❑ Vomiting blood

❑ Black bowel movements

❑ Diarrhea

❑ Blood with bowel movements

❑ Heartburn more than twice weekly? How many years?______________________________________________

❑ Difficulty swallowing

❑ Painful swallowing

❑ Abdominal cramping/bloating

❑ Weight change

❑ Weight one year ago

______________________________________________

______________________________________________

***- next page -***

## Review of Systems:

*Do you now or have you had any problems related to the following systems? Please explain any Yes answers in the space below*

| Yes | No | **Constitutional Symptoms** |
|---|---|---|
| ❑ | ❑ | Fever |
| ❑ | ❑ | Chills |
| ❑ | ❑ | Headache |

Other ___________________________

| Yes | No | **Eyes** |
|---|---|---|
| ❑ | ❑ | Blurred vision |
| ❑ | ❑ | Double vision |
| ❑ | ❑ | Pain |

Other ___________________________

| Yes | No | **Allergic/Immunologic** |
|---|---|---|
| ❑ | ❑ | Hay fever |
| ❑ | ❑ | Drug allergies |

Other ___________________________

| Yes | No | **Neurological** |
|---|---|---|
| ❑ | ❑ | Tremors |
| ❑ | ❑ | Dizzy spells |
| ❑ | ❑ | Numbness/tingling |

Other ___________________________

| Yes | No | **Endocrine** |
|---|---|---|
| ❑ | ❑ | Excessive thirst |
| ❑ | ❑ | Too hot/cold |
| ❑ | ❑ | Thirst/sluggish |

Other ___________________________

| Yes | No | **Gastrointestinal** |
|---|---|---|
| ❑ | ❑ | Abdominal pain |
| ❑ | ❑ | Nausea/vomiting |
| ❑ | ❑ | Indigestion/heartburn |

Other ___________________________

| Yes | No | **Cardiovascular** |
|---|---|---|
| ❑ | ❑ | Chest pain |
| ❑ | ❑ | Varicose veins |
| ❑ | ❑ | High blood pressure |

Other ___________________________

| Yes | No | **Integumentary** |
|---|---|---|
| ❑ | ❑ | Skin rash |
| ❑ | ❑ | Boils |
| ❑ | ❑ | Persistent itch |

Other ___________________________

| Yes | No | **Musculoskeletal** |
|---|---|---|
| ❑ | ❑ | Joint pain |
| ❑ | ❑ | Neck pain |
| ❑ | ❑ | Back pain |

Other ___________________________

| Yes | No | **Ear/Nose/Throat/Mouth** |
|---|---|---|
| ❑ | ❑ | Ear infection |
| ❑ | ❑ | Sore throat |
| ❑ | ❑ | Sinus problems |

Other ___________________________

| Yes | No | **Genitourinary** |
|---|---|---|
| ❑ | ❑ | Urine retention |
| ❑ | ❑ | Painful urination |
| ❑ | ❑ | Urinary frequency |

Other ___________________________

| Yes | No | **Respiratory** |
|---|---|---|
| ❑ | ❑ | Wheezing |
| ❑ | ❑ | Frequent cough |
| ❑ | ❑ | Shortness of breath |

Other ___________________________

| Yes | No | **Hematologic/Lymphatic** |
|---|---|---|
| ❑ | ❑ | Swollen glands |
| ❑ | ❑ | Blood clotting problem |

Other ___________________________

| Yes | No | **Psychologic** |
|---|---|---|
| ❑ | ❑ | Are you generally satisfied with your life? |
| ❑ | ❑ | Do you feel severely depressed? |
| ❑ | ❑ | Have you considered suicide? |

Other ___________________________

_______________________________________________________________

_______________________________________________________________

**Physician use only: (Comments/Notes)**

| # Answer | Level of Service |
|---|---|
| 0-1 | 1 or 2 |
| 2-9 | 3 |
| 10+ | 4 or 5 |

Physician Signature ______________________________________ Date ____/____/____