OVERLAKE INTERNAL MEDICINE - GASTROENTEROLOGY

Date _____

Birthdate _____

Occupation _____
❑Married ❑Divorced ❑Single ❑Widowed

Chief Complaint _____

_____

_____

Family History: **Relation:**
❑Cancer ❑Polyps ❑ Ulcer

❑Liver Disease ❑Pancreatitis

Note any illnesses, if deceased, give age and cause of death:
Father _____

Mother _____

Brothers/ Sisters _____

_____

_____

Spouse _____

Children _____

_____

_____

Do you smoke? ❑Yes ❑No
packages per day _____
of years smoked _____

Do you use alcohol? ❑Yes ❑No
drinks per week _____

Patient Name _____

Illnesses/Surgeries: **Year:**

_____

_____

_____

_____

_____

_____

_____

_____

Medicines:
(list all prescriptions, over-the-counter drugs and vitamins, etc)

_____

_____

_____

_____

_____

_____

Allergies:
Drug: _____

Other: _____

_____

Reviewed by _____ Date _____
Reviewed by _____ Date _____
Reviewed by _____ Date _____

REVIEW OF SYSTEMS

Constitutional
Recent weight change ___No ___Yes
Fever ___No ___Yes
Fatigue ___No ___Yes

Eyes
Blurred vision ___No ___Yes
Glaucoma ___No ___Yes

Ears/Nose/Mouth/Throat
Hearing loss ___No ___Yes
Ringing in ears ___No ___Yes
Mouth sores ___No ___Yes

Cardiovascular
Chest pain ___No ___Yes
Shortness of breath ___No ___Yes
Swelling of ankles ___No ___Yes

Respiratory
Chronic cough ___No ___Yes
Spitting up blood ___No ___Yes
Wheezing ___No ___Yes

Genitourinary
Burning with urination ___No ___Yes
Blood in urine ___No ___Yes

Musculoskeletal
Joint pain or swelling ___No ___Yes
Back pain ___No ___Yes
Muscle pain ___No ___Yes

Skin
Rash ___No ___Yes
Itching ___No ___Yes

Gastrointestinal
Poor appetite ___No ___Yes
Difficulty in swallowing ___No ___Yes
Heartburn ___No ___Yes
Nausea or Vomiting ___No ___Yes
Bloating ___No ___Yes
Belching ___No ___Yes
Regurgitation ___No ___Yes
Constipation ___No ___Yes
Diarrhea ___No ___Yes
Abdominal pain ___No ___Yes
Recent change in bowel habits ___No ___Yes
Rectal bleeding ___No ___Yes
Black, tarry stools ___No ___Yes

Neurological
Headaches ___No ___Yes
Seizures ___No ___Yes
Strokes ___No ___Yes
Numbness ___No ___Yes

Psychiatric
Memory loss or confusion ___No ___Yes
Depression ___No ___Yes

Endocrine
Heat or cold intolerance ___No ___Yes
Excessive thirst or urination ___No ___Yes

Hematological
Bleeding or bruising tendency ___No ___Yes
Anemia ___No ___Yes
Past transfusion ___No ___Yes

Are you pregnant ___No ___Yes

COMMENTS:

REVIEWED:
Date_____ By_____
Date_____ By_____
Date_____ By_____
Date_____ By_____