Central Alabama Gastroenterology
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Patient Name: _____ **today's date:** _____

Reason for visit:

What medication are you allergic to? **If none, write "none."**

_____ _____
_____ _____
_____ _____

What pharmacy do you use? _____

What town is your pharmacy in? _____

Write down all the prescription medications you are taking right now:

_____	dose:_____	how often? _____
_____	dose:_____	how often? _____
_____	dose:_____	how often? _____
_____	dose:_____	how often? _____
_____	dose:_____	how often? _____
_____	dose:_____	how often? _____
_____	dose:_____	how often? _____
_____	dose:_____	how often? _____
_____	dose:_____	how often? _____
_____	dose:_____	how often? _____
_____	dose:_____	how often? _____
_____	dose:_____	how often? _____
_____	dose:_____	how often? _____
_____	dose:_____	how often? _____
_____	dose:_____	how often? _____
_____	dose:_____	how often? _____
_____	dose:_____	how often? _____

Patient name: _____ date of birth: _____ age: _____
Address: _____ City: _____ State: _____ zip: _____
home phone: _____ cell phone: _____ work phone: _____
Sex: _____ social security number: _____
Who do we notify in an emergency?
Name: _____ phone number: _____ relationship_____

YOUR E-MAIL ADDRESS: _____

Please list below anyone we can speak with regarding your medical information or appointments:
WRITE THAT PERSON'S NAME HERE: _____

Referring physician: _____ Primary care physician: _____
PLEASE NOTE: Notify office at least 24 hours in advance to cancel or reschedule and office visit, office procedure, or a procedure done at Russell Medical Center. Office visit no show fee is $50 and procedure no show fee is $50. Also, our office is a specialty office. All visits, regardless of the provider you see, are reviewed by Dr. Holcombe. Therefore, a specialty office visit copay is applied.

MEDICAL HISTORY: Please check if YOU have any of the following diseases:

- o acid reflux
- o cancer (_____ what kind?)
- o chest pain
- o dementia
- o diabetes
- o endometriosis
- o heart attack
- o heart failure
- o high blood pressure
- o high cholesterol
- o irregular heartbeats
- o COPD
- o mitral valve prolapsed
- o prior chemotherapy
- o prior radiation treatment
- o stroke
- o thyroid disorder
- o ulcer
- o other _____
- **o none**

YOUR GASTRO HISTORY: Please check if YOU have any of the following:

- o colon cancer
- o colitis
- o polyps
- o Crohn's
- o diverticulosis
- o gastritis
- o GERD
- o hepatitis
- o liver disease
- o gall stones
- o irritable bowel
- o pancreatitis
- o jaundice
- o hiatal hernia
- o heartburn/indigestion
- o rectal bleed

date of your last colonoscopy: _____
facility/location of last colonoscopy: _____
Was last colonoscopy normal? _____

date of last EGD (scope down throat): _____
facility/location of last EGD: _____
Was last EGD normal? _____

YOUR SURGICAL HISTORY: Please check if YOU have had any of the following:

- **o none**
- o abdominal aneurysm
- o abdominal hernia
- o abdominal hysterectomy
- o angioplasty
- o appendectomy
- o back surgery
- o bladder
- o breast surgery
- o C-section
- o cataracts
- o cervical disc
- o colon
- o defibrillator
- o gallbladder
- o heart by pass
- o heart stent
- o heart valve
- o hernia (left)
- o hernia (right)
- o joint surgery
- o kidney stone surgery
- o ovary
- o pacemaker
- o prostate
- o splenectomy
- o stomach ulcer
- o tonsils
- o tubal ligation
- o vaginal hysterectomy
- o other _____

YOUR **FAMILY** HISTORY: Write down which **family** members have had the following:

*Write ***father, mother, brother, sister, son, or daughter.***

- o breast cancer _____
- o cancer/type? _____
- o high blood pressure _____
- o liver disease _____
- o gall stones _____
- o melanoma _____
- o thyroid disease _____
- o arthritis _____
- o stroke _____
- o Crohn's Disease_____
- o bleeding disorder _____
- o diabetes _____
- o kidney disease _____
- o ulcerative colitis _____
- o colon polyps _____

o none/ no family history of any of these diseases

YOUR SOCIAL HISTORY: Please check all that apply to **you.**

Marital Status:

- o married
- o single
- o divorced
- o widowed
- o separated
- o student

Occupation:

- o employed
- o unemployed
- o self-employed
- o disabled
- o retired

Alcohol use:

- o never drank
- o never drink anymore
- o drink daily
- o how many drinks per day _____
- o how many years ____
- o occasionally drink

Tobacco use:

- o never used tobacco
- o former smoker
- o smoker
- o chew or dip tobacco
- o recreation drug use: what kind?_____

Review of Symptoms: Please check the symptoms that **you** have experienced over the last **two weeks:**

General health:
O fever
O chills
O fatigue
O weight loss
O other ___

G/U:
O difficulty urinating
O blood in urine
O change in sexual
O other ___

Neurological:
O tremors
O dizzy spells
O memory problems
O seizures
O other ___

Eyes:
O blurred vision
O double vision
O glaucoma
O other ___

Endocrine:
o excessive thirst
o hot/cold intolerance
o hot flashes
o other ___

Psychiatric:
o depression
o anxiety
o irritable
other___

Ear/nose/throat:
o ear infection
o sore throat
o sinus problems
o other ___

Integumentary:
o skin rash
o boils
o persistent itch
o other ___

Cardiovascular:
o chest pain
o varicose veins
o palpitations
o high BP
o other ____

Hematologic/lymphatic:
o abnormal bruising
o enlarged lymph nodes
o anemia
other ___

Respiratory:
o wheezing
o frequent cough
o shortness of breath
o other ___

Musculoskeletal:
o joint pain
o neck/back pain
o bone pain
o other ___

Gastroenterology:
o abdominal pain
o nausea
o vomiting
o indigestion/heartburn
o bloating/gas
o difficulty swallowing
o loss of appetite
o blood in stool
o diarrhea
o constipation
o rectal bleeding
o hemorrhoids
o other ___