

prevention diagnosis treatment surgery www.gispecialistsmemphis.com

Patient Name _____ DOB _____ Age _____ Date _____

Reason for today's visit _____

SYSTEMS REVIEW Please circle YES or NO for each question.

CONSTITUTIONAL SYMPTOMS

Headache	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue/Tired	No	Yes
Night Sweats	No	Yes

MUSCULOSKELETAL

Joint pain / stiffness	No	Yes	_____
Muscle weakness /cramps	No	Yes	_____
Back pain	No	Yes	(body area)
Neck pain	No	Yes	
Cold extremities	No	Yes	
Arthritis	No	Yes	

CARDIOVASCULAR

Heart trouble	No	Yes
Chest Pain	No	Yes
Chest tightness	No	Yes
Pain in legs	No	Yes
Swelling feet/hands	No	Yes
Palpitations (racing)	No	Yes
High Blood Pressure	No	Yes

SKIN

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair/nails	No	Yes
Varicose veins	No	Yes

RESPIRATORY

Chronic cough	No	Yes
Frequent cough	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
With walking	No	Yes
Lying flat	No	Yes

NEUROLOGICAL

Dizziness	No	Yes
Fainting spells	No	Yes
Blurred/cloudy vision	No	Yes
Convulsion/seizures	No	Yes
Numbness/tingling	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes

GASTROINTESTINAL

Loss of appetite	No	Yes
Nausea/vomiting	No	Yes
Abdominal pain	No	Yes
Heartburn / Reflux	No	Yes
Peptic ulcer	No	Yes
Excess gas, bloating	No	Yes
Difficulty swallowing	No	Yes
Change in bowel habits	No	Yes
Diarrhea	No	Yes
Painful bowel movement	No	Yes
Constipation	No	Yes
Blood in stool	No	Yes
Rectal Bleeding	No	Yes

HEMATOLOGIC/LYMPATHIC

Easy bruising	No	Yes
Prolonged bleeding	No	Yes
Anemia (low blood count)	No	Yes
Past blood transfusion	No	Yes
Abnormal blood clotting	No	Yes
Hemophilia	No	Yes

GENITOURINARY

Frequent urination	No	Yes
Burning urination	No	Yes
Blood in urine	No	Yes
Incontinence (loss of control)	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes

PSYCHIATRIC

Memory loss/confusion	No	Yes
Anxiety	No	Yes
Depression	No	Yes
Insomnia / Difficulty sleeping	No	Yes

Are you experiencing any symptoms not on this list?

_____ (over)

Patient Name _____

ALLERGIES (please circle any that apply)

None Penicillin Aspirin Sulfa
Iodine Eggs Latex Contrast Dye
Other _____

PAST & CURRENT ILLNESSES (please circle all that apply)

Asthma Cirrhosis Colon Polyps Crohn's Disease
Diverticulitis GERD Gallstones Hernia
Hepatitis Irritable Bowel Pancreatitis Stomach Ulcer
Ulcerative Colitis Parkinson's Disease Seizures Stroke
Cancer (type) _____ Blood Transfusions Thyroid Disease Pneumonia
HIV/AIDS Sexually Transmitted Diseases Tuberculosis Arterial Blockages
Heart Failure High Blood Pressure High Cholesterol Rheumatic Fever
Fibromyalgia Lupus Melanoma Osteoporosis
Urinary Infection Kidney Disease/Failure Ovarian Cysts Diabetes
Other: _____

PLEASE LIST PREVIOUS OPERATIONS / TREATMENTS _____

How would you rate your general health? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Do you Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much?	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much?
Have you ever had a drug abuse problem? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type?	Have you ever been exposed to HIV (AIDS)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	

FAMILY HISTORY

Have any blood relatives had the following (Father, Mother, Sister, Brother, Child(ren)):

Heart Problems No Yes Who: _____
Celiac Disease No Yes Who: _____
Colitis No Yes Who: _____
Crohn's Disease No Yes Who: _____
Liver Disease No Yes Who: _____
Colon Polyps No Yes Who: _____
Stroke No Yes Who: _____
Cancer No Yes Who/Type : _____
(Breast, Colon, Ovarian, Pancreatic, Stomach, other)
Other Chronic Disease No Yes Who: _____