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PATIENT QUESTIONNAIRE & HISTORY

(Please fill in ALL blanks completely)

Name: DOB: Date:
Address: City: State: Zip:
Telephone Number: (Home) (Work) (Cell):
Age: Sex: Weight: Height: Referring Doctor:

REASON FOR YOUR VISIT TODAY, (If any checked indicate how often):

- Stomach/abdominal pain Rectal Bleeding Trouble Swallowing Abnormal Liver Tests
Constipation Black Stools Indigestion Other/Comments
Diarrhea Nausea/Vomiting Weight loss/gain

HISTORY

(Have you had or are you being treated for any of the following conditions (check all that apply))

- High Blood Pressure Heart Disease Irreg. Heart Beat (arrhythmia) Heartburn/Acid Reflux (GERD) Excessive Bleeding Stroke Anxiety Crohns Anemia Numbness in arms/legs
Asthma Fluid in Lungs Liver Problems Hepatitis Kidney Problems Seizures/Epilepsy Irritable Bowel Syndrome Colitis C-Diff COPD/Emphysema
Mitral Valve Prolapse Thyroid Disease HIV Diabetes Depression Diverticulosis/Diverticulitis Barretts Esophagus H-Pylori Cancer Pancreatitis

Have you ever had a heart attack (myocardial infarction)?
If yes, what month/year(s)?
Have you had a heart valve replacement, if yes when
Have you used alcohol or other drugs? If so, how much per day?
Is there any chance that you are pregnant? Date of last period
Do you smoke currently (or within the last six months regularly)?
Do you use/take alternative therapies? i.e. vitamins or supplements
Do you take any prescription blood thinners, or aspirin?
Do you take antibiotics prior to dental surgery?
Do you have any Allergies to medicines or foods?
Allergy to Penicillin?

PREVIOUS MEDICAL CONDITIONS

(Have you had any of the following surgeries?)

- Gallbladder Removal Abdominal Hysterectomy Vaginal Hysterectomy Bowel Resection Gastric Bypass Surgery
Gallstones treated Tubal Ligation Stomach Ulcer Surgery Appendix Removed Ovaries Removed
Throat Surgery Sleep Apnea Snoring Other Surgery

Do you have a family history of:
If yes please indicate which family member
Please list your current Medications, include doses and time of day:

If you are here for an EGD or a Colonoscopy please check all that apply:

- My Primary has referred me due to the following symptoms
My Primary has recommended a screening, my age is
This is my first Colonoscopy/EGD
I have had a Colonoscopy/EGD, performed at by