Kalamazoo Endo Center – Portage **Patient Information Sheet & Health History**

Please fill out the following form completely so that we may obtain the necessary information for our files and background information on your medical problem. In this way, more time will be available for you to talk to the doctor at the time of your visit. All information is held in strict confidence and will not be released to anyone without your written consent. Thank you for your patience and assistance.

Patient Information – Please print all information

Date:_____

Name:_____ Date of Birth ___/___/_____ Age:_____ Email:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Race/Ethnicity:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Preferred Language:_____ Gender: ◻Female ◻ Male ◻ Transgender/Other

Primary Care Physician/Referring:_____

Lab preferred for pathology: ◻ Bronson Healthcare Group

In your own words, why are you here to see the doctor today? (main concern, severity, how long, pain level, etc.)

_____

Medication Allergies: Please include type of reaction.

Medication	Type of Reaction:

Social History:

❒ Tobacco use? Cigarettes_____ Smokeless_____

Packs / Day_____ # Years_____ Date Quit_____

❒ Medical Marijuana use_____ # Years_____

❒ Alcohol Use: In the past?_____

How much daily_____ Weekly_____

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Partner

Sexually active: ❒ Yes ❒ No

❒ Recreational drug use: If checked, please list

_____

❒ Recent foreign travel: When?_____

Where?_____

Do you feel safe at home? ❒ Yes ❒ No

❒ Special Diet: What type?_____

Family History:

❒ Colon cancer – Relation_____

❒ Liver disease/cirrhosis – Relation_____

❒ Colon polyps – Relation_____

❒ Diabetes – Relation_____

❒ Heart Disease – Relation_____

❒ Stomach Cancer – Relation_____

❒ Esophagus cancer – Relation_____

❒ Other Cancer – Relation_____

❒ Gallstones – Relation_____

❒ Pancreatitis – Relation_____

❒ Crohn's Disease or Ulcerative Colitis – Relation

_____

Past Medical History: *Check all that apply to you*

General:

- ❒ Irregular heartbeat
- ❒ Heart attack/failure
- ❒ Diabetes
- ❒ HTN
- ❒ Breathing problems (asthma/COPD/Emphysema)
- ❒ HIV
- ❒ Stroke
- ❒ Cancer and type
- ❒ Pacemaker
- ❒ Prostate problems
- ❒ Arthritis/gout
- ❒ Bleeding disorders
- ❒ High Cholesterol
- ❒ Kidney disease
- ❒ Thyroid
- ❒ Psychiatric
- ❒ Mood changes
- ❒ Depression
- ❒ Insomnia
- ❒ Anxiety

Gastrointestinal:

- ❒ Anemia
- ❒ Celiac
- ❒ Gall stones
- ❒ Cirrhosis
- ❒ Colon polyps
- ❒ PUD
- ❒ Diverticulitis
- ❒ Esophageal stricture
- ❒ Food intolerance
- ❒ Gastroparesis
- ❒ Liver disease
- ❒ Cancer (colon, esophageal, liver, pancreatic, rectal, stomach)
- ❒ GERD
- ❒ Hemochromatosis
- ❒ Hepatitis
- ❒ Hernia
- ❒ Small bowel obstruction
- ❒ IBS
- ❒ Crohn's Disease
- ❒ Pancreatitis
- ❒ Ulcerative colitis

Past Surgeries/GI tests:

- ❒ Appendix
- ❒ Gallbladder
- ❒ ERCP
- ❒ Esophagus
- ❒ Tonsils
- ❒ Colon (surgery, colonoscopy, polyp removed)
- ❒ EGD
- ❒ Heart_____
- ❒ Lung
- ❒ Kidney
- ❒ Thyroid
- ❒ Vascular_____
- ❒ Uterus
- ❒ C-Section
- ❒ Hysterectomy
- ❒ Mastectomy (R or L)
- ❒ Back
- ❒ Transplants?
- ❒ Liver (biopsy/surgery)
- ❒ Small intestine surgery

Hospitalizations/ Surgeries: in the last 6 months	Date: Month/Year

Review of Systems: Check all that apply to you

General:

❒ Appetite loss ❒ Fatigue ❒ Fever ❒ Chills ❒ Night sweats

❒ Weight loss / weight gain - How much?_____ In what time period?_____

Eyes, Ears, Nose, Throat:

❒ Congestion ❒ Swollen glands ❒ Sore throat ❒Mouth sores ❒Ear pain

Lungs:

❒ Cough ❒ Wheezing ❒ Shortness of breath ❒ Asthma ❒ Coughing up blood

❒ Sleep trouble due to breathing

*at rest*_____

*at night*_____

*with exertion*_____

❒ Home oxygen

Skin:

❒ Itching ❒ Rash ❒ Bruising ❒Bleeding

Heart:

❒ Chest pain ❒ Irregular heartbeats ❒ Leg pain or swelling ❒ Palpitations
❒ Difficulty breathing lying down ❒ Fainting or blacking out

Endocrine:

❒ Excessive thirst ❒ Hot or cold intolerance ❒ Excessive urination

Bones/Joints:

❒ Arthritis ❒ Falls ❒Neck pain ❒ Joint pain ❒ Back pain
❒ Muscle weakness

GI:

❒ Abdominal bloating ❒ Abdominal pain ❒ Bowel habit changes ❒ Blood in vomit
❒ Diarrhea ❒ Trouble swallowing ❒ Gas ❒ Nausea
❒ Blood in stool ❒ Hemorrhoids ❒ Constipation ❒ Yellowing of skin (jaundice)
❒ Vomiting ❒ Heartburn

Urinary:

❒ Blood in urine ❒ Difficulty urinating ❒ Dark urine ❒ Incontinence

Comments:_____

_____

_____ ____/____/_____ ____/____/_____
Patient Signature/or Legal Guardian Signature **Date of Birth** **Today's Date**

_____ _____ _____
Physician Signature **Date** **Time**