Grayson
Digestive Disease Consultants PLLC.

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Date: _____ Age:_____

Name: _____ DOB:_____ Ht:_____ Wt:_____

Chief Complaint (why are you here?): _____
_____

Referring Physician:_____

Pharmacy name/location:_____

Pharmacy phone number: _____

MEDICAL HISTORY:

Patient Medical History

Diabetes	No	Yes	Elevated Cholesterol	No	Yes
Cancer	No	Yes	Hypertension	No	Yes
Heart trouble	No	Yes	Stroke	No	Yes
Convulsions/Seizures	No	Yes	Arthritis/Gout	No	Yes
Acute Infections	No	Yes	Bleeding Tendency	No	Yes
Hereditary Defects	No	Yes	Crohn's Disease	No	Yes
Diverticulitis	No	Yes	Ulcerative Colitis	No	Yes
Ulcer Disease	No	Yes	Lung Disease	No	Yes
Diarrhea	No	Yes	Liver Disease	No	Yes
Constipation	No	Yes	Colon Polyps	No	Yes
Thyroid Disease	No	Yes	Dementia	No	Yes

Additional Medical Problems:_____
_____
_____

Surgeries/When?:_____
_____
_____
_____
_____
_____

Medications:_____
_____
_____
_____

Allergies:_____
_____
_____

Recent Studies and Procedures /When?: CT scan_____
Ultrasound_____ Small Bowel Xray_____ EGD_____
Colonoscopy_____ ERCP _____
EUS_____ other_____

Patient social history

Marital status: Single___ Married___ Separated___ Divorced___ Widowed___
Use of alcohol: Never___ Rarely___ Moderate___ Daily___ Socially____
Use of Tobacco: Never___ Previously, but quit___ Currently__ Packs/day___
Use of drugs: Never___ If yes, Type/Frequency _____
Occupation: _____

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____

Signature Date Time
_____ _____ _____