Cleveland Gastroenterology Associates, P.A.
808 N. Washington Street, Shelby, NC 28150; Phone: 704-480-0008, Fax: 704-480-5988

PATIENT INFORMATION SHEET

Name_____ **Sex: F M DOB**_____ **Age**_____ **Date**_____

Marital Status: Single_____ Married_____ Divorced_____ Widowed_____ Number of Children_____

Occupation:_____ **Since Year:**_____

Race: (Please Circle) American Indian/Alaska Native Asian African American Caucasian Pacific Islander Declined Other

Physician: (Please Circle) Dr. Smith Dr. Rybnicek Lavonia Womack, NP Megan Stephens, NP Pam Burr, NP

Primary Care Physician_____ **Referred By**_____

It is important for our Physicians/ NPs to have your complete health history. Please help us by taking the time to provide this information accurately and completely. This information will be a confidential part of your medical record.

PAST SURGICAL AND MEDICAL HISTORY-Check ALL that apply

MEDICAL HISTORY	X	Onset, Comments	SURGICAL HISTORY	X	Date, Comments
Anorexia / Bulimia			Colon		
Arthritis / Joint Swelling			Stomach		
Asthma			Heart:		
Bleeding Disorder			Stent / Bypass		
Blood or Infectious Disease			Valve		
Cancer, Type:			Pacemaker		
Colon Polyps			Defibrillator		
Crohn's Disease			Joint Replacement		
Diabetes, Type 1 or 2			Gallbladder		
Epilepsy / Seizures			Hysterectomy		
Anxiety			Appendix		
Depression			Prostate		
Gallstones			Bladder		
Glaucoma			C-Section		
Headaches / Fainting / Dizziness			Abortion		
Heart Problems / Chest Pain			Breast		
High Cholesterol			Other Surgeries: (Please List)		
Liver Disorders					
Hiatal Hernia / GERD					
High / Low Blood Pressure					
Kidney Disease					
Lung Disease					
Sleep Apnea / CPAP			Anesthesia Problems		
Stomach Disorders / Ulcers			Previous EGD		
Stroke			Previous Colonoscopy		
Thyroid Problems					
Tuberculosis			Hepatitis A		
Ulcerative Colitis			Hepatitis B		
Menopause (Age)			Hepatitis C		

Name:_____ Date of Birth:_____

SOCIAL HISTORY:				
Alcohol	Past	Current	Never	Duration & Amount
Coffee / Caffeine	Past	Current	Never	Duration & Amount
Substance Abuse	Past	Current	Never	Duration & Amount
Tobacco	Past	Current	Never	Duration & Amount
Blood Transfusions	Yes	No	When?	
Tattoos	Yes	No		
Do you exercise?	Yes	No	How much?	
FAMILY HISTORY: Please indicate any **RELATIVES** with the following diseases.				
Alcoholism	Yes	No		
Cirrhosis / Jaundice	Yes	No		
Colon Cancer	Yes	No		
Colon or rectal polyps	Yes	No		
Crohn's/Ulcerative Colitis	Yes	No		
Diabetes	Yes	No		
Gallstones	Yes	No		
Hemachromatosis	Yes	No		
Heart disease	Yes	No		
High Blood Pressure	Yes	No		
Liver Disease	Yes	No		

SYMPTOM REVIEW Check (☒) symptoms you currently have or have had in the past

General:
☐ Weight Loss_____lbs
☐ Weight Gain_____lbs
☐ Fatigue
☐ Fever

Eyes:
☐ Changes in Vision
☐ Glaucoma
☐ Cataract

HENT:
☐ Headache
☐ Injury (Head)
☐ Dizziness
☐ Deaf or Uses Hearing Aid
☐ Cold
☐ Dentures
☐ Hoarseness
☐ Sore Throat

Breast:
☐ Lumps
☐ Discharge

Cardiac:
☐ High Blood Pressure
☐ Chest Pain
☐ Palpitations
☐ Shortness of Breath

Respiratory:
☐ Cough
☐ Wheezing
☐ Emphysema
☐ Snoring
☐ Uses CPAP/ Sleep Apnea
☐ TB Exposure

Gastrointestinal:
☐ Ulcers
☐ Jaundice
☐ Polyps
☐ Diarrhea
☐ Constipation
☐ Rectal Bleeding
☐ Heartburn
☐ Reflux
☐ Difficulty Swallowing
☐ Nausea
☐ Vomiting
☐ Hernia

Genitourinary:
☐ Urgency
☐ Hesitancy
☐ Frequency
☐ Infections
☐ Stones
☐ Hernia
☐ Venereal Disease
☐ Menstrual Irregularity

Skin:
☐ Rash
☐ Lumps
☐ Itching
☐ Hair Change/Loss

Neurologic:
☐ Tingling/Numbness
☐ Muscular Weakness
☐ Fainting/Blackouts
☐ Seizures
☐ Tremors

Musculoskeletal:
☐ Joint Pain/Stiffness
☐ Gout
☐ Osteoporosis
☐ Osteoarthritis

Psychiatric:
☐ Anxiety
☐ Depression
☐ Suicide Attempt
☐ Nervous Breakdown

Other Physicians Who Are Actively Treating You:	
Pain Clinic:	Condition:
Doctor:	Condition:
Doctor:	Condition:

Patient Signature: _____ Date: _____