Pezzone Gastroenterology Associates

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New Patient Information

Your Name:____________________________
Your Birth date:__________________________

This form is to help your doctor give you better health care. It is completely confidential and will be part of your medical record. Please ***write your name*** *on every page!*

Would you say in general your health is: ▢Excellent ▢Very Good ▢Good ▢Fair ▢Poor ▢Rather not answer ▢Unsure	
Thinking about your health **for how many days** in the **past 30 days,** was your:	Number of days
1....physical health **not good** *(including injury and pain)*	
2....emotional health **not good** *(including stress, depression and problems with emotions)*	
3. How many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work or recreation?	

List All of the Medications You Take Now

Medication	Dose (mg)	Frequency (times per day)

Allergies Include medicines, food, environmental or any other

Chief Complaint / **Reason for today's visit**

Your Name________________________

Operations or serious illnesses			
Month/Year	Reason	Hospitalized?	
		YES	NO
1)		☐	☐
2)		☐	☐
3)		☐	☐
4)		☐	☐
5)		☐	☐
6)		☐	☐
7)		☐	☐
8)		☐	☐
9)		☐	☐
10)		☐	☐
Cancer:	**Have you ever had or do you have?**	☐	☐

Body part / Year	Hospital / Doctor's Office where you received treatment
1) Year	Name: Phone: Address: ☐Surgery ☐Chemotherapy ☐Biotherapy ☐Radiation ☐Radiation Implants
2) Year	Name: Phone: Address: ☐Surgery ☐Chemotherapy ☐Biotherapy ☐Radiation ☐Radiation Implants
3) Year	Name: Phone: Address: ☐Surgery ☐Chemotherapy ☐Biotherapy ☐Radiation ☐Radiation Implants

FAMILY HISTORY	Present Age	Age of Death	Present Health or Cause of Death
Father			
Mother			
☐Brother☐Sister			
☐Brother☐Sister			
☐Brother☐Sister			
☐Brother☐Sister			
☐Brother☐Sister			
Spouse/Partner			

SYMPTOMS *Check ALL you are currently experiencing:* Your Name________________________

Gastrointestinal

__Loss of Appetite
__Heartburn or Indigestion
__Stomach discomfort, cramping, pain
__Frequent Nausea/Vomiting
__Recurrent Diarrhea
__Constipation
__Bloody Stools
__Black, tarry stools
__Difficulty Swallowing/Chewing

Nutritional Data

__Recent Weight Loss (Amount____)
__Recent Weight Gain (Amount____)
__Difficulty Chewing or Swallowing
__Food Supplements (vitamins/minerals/herbs)
__Diet Type (Regular or Restricted)
__Number of meals a day _______
__Do you drink caffeinated drinks?
▢YES ▢NO
How many ounces a day?_____
__Do you drink water?
▢YES ▢NO
How many ounces a day?

Hematologic/Lymphatic

__Easy Bleeding/Bruising
__Blood Clots ____________ Location
__Ankle Swelling
__Anemia
__Blood Problem
__Swelling of Glands
__Swelling of Hands/Feet

Cardiovascular

__High Blood Pressure
__Rapid/Irregular Heart Beat
__Heart Murmur
__Chest Pain
__Leg Cramps

Respiratory

__Stop breathing while sleeping
__Frequent cough
__Cough that produces blood
__Difficulty breathing or catching breath
__Wear oxygen at home

Genitourinary/Sexual/Intimacy

__Reproductive Concerns
__Sexual Abuse
__Difficulty Urinating
__Frequent/Painful Urination
__Recurrent Bladder Infection
__Nipple Discharge
__Change in Breast Size
__Breast Lump/Pain
__Female: Vaginal Itching

HEENT

__Vision Loss
__Hearing Loss
__Mouth Ulcers/Sores
__Dental Problems
__Hoarseness
__Nosebleeds

Musculoskeletal

__Difficulty Walking
__Joint Aches or Stiffness
__Cramping
__Ankle or Other Joint Swelling
__Need Help With:
▢Eating ▢Dressing ▢Walking

Neurological/psych/Social

__Difficulty Concentrating
__Frequent Headaches
__Dizziness/Fainting
__Numbness Hands or Feet
__Memory Changes
__Feeling Overwhelmed
__Anxious/Nervous
__Trouble Sleeping/Nightmares
__Lonely/Depressed
__Work/Family Problems
__Tire Easily
__Worried about Family Matters
__Physical, emotional, verbal abuse
__Concerns how illness will affect your finances

Endocrine

__Thyroid Problems
__Blood Sugar Problems
__Excessive Sweating

Integumentary/Infectious

__Sores/Rashes
__Changes in Moles
__Change in Skin Color
__Frequent Infections
__Fevers
__Night Sweats
__Excessive Itching

Prosthetic Devices

__Eye Glasses/Contacts
__Dentures
__Pacemaker
__Artificial Limb (Type_________)
__Implants (Type_________)
__Pacemaker/Defibrillator

Access Devices

Do you have a catheter, tube or port in your arm, chest or abdomen for drawing blood, receiving medication or removing fluid?
▢Yes ▢No
If Yes, Last used_______________

Medical History: Your Name________________________

Check the box **if** you have ever been diagnosed with: ☐ **No Known Medical Problems**

Gastrointestinal
__GERD or Reflux
__Barrett's Esophagus
__Irritable Bowel Syndrome
__Colorectal Disease/Cancer
__Gall Bladder Problems
__Ulcerative Colitis
__Crohn's Disease
Last Sigmoid Exam
____
Last Colonoscopy
____

Hematologic/Lymphatic
__Jaundice/Hepatitis
__Other Liver Disorder

Respiratory
__Lung Disorder
(Asthma, Bronchitis, Emphysema)
__Asthma/Hives
__Sleep Apnea

Cardiovascular
__Heart Disease/Heart condition
__Heart Attack/Heart Failure
__Rheumatic Fever/Angina
__Rapid or Irregular Heart Beat
__Abnormal Cardiogram (EKG)
__Stroke/Hypertension
__Anemia/Blood Problems
__Blood Transfusion #_______
Reaction ☐Yes ☐No
__Mitral Valve Prolapse

GU
__Kidney/Bladder Problem
__Breast/Prostate Problem

Musculoskeletal
__Arthritis/Chronic Pain

HEENT
__Glaucoma/Cataracts

Musculoskeletal
__Arthritis/Paralysis
__Multiple Sclerosis/Muscular Dystrophy

Neurological/Psychological
__Nervous Disorder
__Seizure Disorder
__Depression
__Anxiety

Endocrine
__Thyroid Problem
__Diabetes
__Eczema/Psoriasis
__Birth Defect/Inherited Disease

Integumentary/Infectious
__Chicken Pox
__Measles/Mumps/Rubella
__MRSA/VRE/C-Diff
__AIDS/HIV
__Venereal Disease/Herpes

Lifestyle Factors

Caffeine and Fluids				
How many do you drink a day?	Cups of **Coffee**			
	Cups of **Tea**			
	Cans of **Cola**			
	Ounces of **Water**			
Tobacco				
Do you smoke or use tobacco products?	☐Yes	☐Never	☐Passive	☐Quit (Date________)
Packs/day____________ # of Years_____________ Type: ☐Cigarettes ☐Cigars ☐Pipe ☐Chew ☐Snuff				
Alcohol and Drugs				
Do you drink alcohol? Includes beer, wine, distilled spirits/liquor	☐Yes		☐No	
If Yes, how many drinks do you have in a typical: day _______ week _______ month ________ ? ☐ Glasses of wine ☐Cans of beer ☐Shots of liquor				
Do you use any "street" dugs? Cocaine, marijuana, methamphetamines			☐ Yes ☐ No	Times per week ☐

Demographics	Your Name
Date of Birth: ______________________ Age________________	Please list any other physicians to whom you would like Copies of information sent:
Address:	Name: Address:
Home Phone: ( ) - Cell Phone: ( ) - Work Phone: ( ) -	Reason for seeing:
Lifetime Occupation: Retired: ▢Yes ▢No Employer:	Name: Address: Reason for seeing:
How did you hear about Pezzone Gastroenterology Associates? ▢Family/Friend ▢Yellow Pages ▢Television ▢Newspaper ▢Internet ▢Pittsburgh Magazine	Name: Address: Reason for seeing
Marital Status: ▢Single ▢Married ▢Widowed ▢Divorced Name of Spouse:	Name: Address:
Practices: Are there any religious, ethnic or cultural practices that need to be part of your care? ▢Yes ▢NO	Reason for seeing
Living Arrangements: ▢Alone ▢Spouse ▢Significant Other ▢Supervised Living ▢Other: **Services in your Home:** ▢None ▢Aide ▢Nurse ▢Meals on Wheels ▢Home Care Agency Name:	**Contacts:** Please list a person, who does not have the same phone Number as you, to call if we are unable to reach you. Name: Address: Home Phone: ( ) - Work Phone: ( ) - Relationship:
Your Pharmacy Name: Phone: ( ) - Address:	**Emergency Contact:** Please list a person you would like us to contact in case of Emergency. Name: Home Phone: ( ) - Work Phone: ( ) - Relationship:

Thank You