Denver Digestive Health Specialists
shedding light on gastrointestinal problems

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INITIAL GASTROENTEROLOGY CONSULTATION

Note: This is a confidential record that will be kept in your records in our office and will not be released to anyone without your authorization to do so.

Name: (print clearly) _____

M or F? _____ Today's Date: _____

Dr. performing consult: _____ Age: _____

Referring doctor: _____ Date of your last physical examination: _____

What is your chief complaint today? _____

_____

Regarding this illness, do you have or have you had:

O Abdominal Pain	O Fever	O Heartburn/reflux	O Nausea
O Vomiting	O Blood in vomit	O Difficulty swallowing	O Diarrhea
O Regurgitation of food	O Change in appetite	O Yellow skin/eyes	O Constipation
O Red blood in stool	O Black/tarry stools	O Unintended weight loss	

Please list your medical history: _____

_____

_____

_____

Please list all your previous surgeries and dates:

Date _____ Surgery _____ Date _____ Surgery _____

Date _____ Surgery _____ Date _____ Surgery _____

Date _____ Surgery _____ Date _____ Surgery _____

Please list all your current medications. Include birth control, aspirin, over the counter medicine or homeopathic medicine:

_____ _____ _____

_____ _____ _____

DRUG ALLERGIES AND TYPE OF REACTION: _____

Smoke? O yes O no O former How much? _____ Last Use: _____

Alcohol? O yes O no O former Type and amount per week _____

Recreational drugs? O yes O no Type and date of last use _____

Which vaccinations have you had?

O Hepatitis A Year completed _____ O Hepatits B Year Completed _____

O Pneumonia Vaccine Year completed _____ O Influenza

Family Health (please list any health problems or cancers your immediate family has had):

Mother: _____ Father: _____

Siblings: _____ Grandparents: _____

Aunts/Uncles: _____

REVIEW OF SYSTEMS (PLEASE CHECK ONLY THOSE CONDITIONS THAT YOU HAVE OR HAVE HAD IN THE PAST)

Skin: Change in: O Moles O Moisture O Texture (dry or oily)
Do you have: O Bleeding O Easily bruise O Lesions O Itching O Scaling

Eyes: O Color blindness O Pain O Change in vision O Visual loss

Throat: O Change in voice O Frequent sore throat O Hoarseness O Pain/difficulty swallowing

Breast: O Lumps O Nipple discharge O Change in size O Skin lesions O Change in skin color

Endocrine:
- O Abnormal body growth or body configuration
- O Excessive sweating/loss of sweating
- O Increased thirst, urination or hunger
- O Infertility, or any hormonal abnormality
- O Unusual sensitivity or insensitivity to hot or cold

Cardiovascular:
- O Chest Pain
- O Cold and/or hot feet
- O Irregular heart rate or rhythm
- O Pain in legs after walking
- O Palpitations
- O Shortness of breath after exercise
- O Shortness of breath at night before sleeping
- O Shortness of breath at night that awakes you
- O Swelling of hands and/or feet

Respiratory:
- O Wheezing
- O Coughing
- O Sputum production (coughing up mucus)
- O Shortness of breath at rest
- O Shortness of breath after walking ___blocks

Genitourinary:
- O Change in color of urine
- O Frequent urination at night
- O Erectile Dysfunction
- O Decreased urination
- O Increased urination
- O Painful urination
- O Change in menstrual cycle

Neurological:
- O Decrease in muscle strength (specify where)_____
- O Loss of sensation
- O Numbness
- O Burning pain
- O Tingling

Rheumatological:
- O Muscle pain, swelling or tenderness (specify where)_____
- O Joint pain, swelling or tenderness (specify where)_____

Blood: O Anemia O History of blood transfusions O Bleeding disorders

Constitution:
- O Night sweats
- O Fatigue
- O Generalized weakness of muscles
- O Fever
- O Weight loss

_____ _____
Patient Signature Date

_____ _____
Physician Signature Date