Cascade Gastroenterology
Specialized Digestive Care

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New Patient Information

Name:_____ **Date of Birth**:_____

Reason for visit:_____

Marital Status: O Single O Married O Divorced O Widowed O Separated

Occupation:_____ O Student O Retired O Disabled O Unemployed

Preferred Pharmacy:_____

Primary Care Provider:_____

Drug Allergies:

Medication	Reaction(s)
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications:

Name	Dose	Quantity	Name	Dose	Quantity
_____	_____	____/Day	_____	_____	____/Day
_____	_____	____/Day	_____	_____	____/Day
_____	_____	____/Day	_____	_____	____/Day
_____	_____	____/Day	_____	_____	____/Day
_____	_____	____/Day	_____	_____	____/Day
_____	_____	____/Day	_____	_____	____/Day
_____	_____	____/Day	_____	_____	____/Day

Alcohol use: O Yes O No

Type:_____ # of drinks per day/week/month:_____ Year started:_____

Tobacco Use: O Yes O No

If Yes:

Form:_____

Amount/day:_____

Year started:_____

If Previous:

Form:_____

Amount/day:_____

Quit Date:_____

Recreational Drug Use:

Current: O Yes O No If yes, what kind? _____

Past: O Yes O No If yes, what kind? _____

Caffeine Use: O Yes O No

If yes, what type? _____ How many servings per day? _____

Significant foreign travel in the past 2 years? O Yes O No

If yes, where and when?

_____

Past Hospitalizations:

When	Where	For What Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Surgical & Procedural History:

Surgery	Date	Performing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Date of last colonoscopy: _____ Performing physician:_____

Polyps removed? O Yes O No

If yes, were the polyps: O precancerous O benign

When were you advised to repeat a screening colonoscopy?_____

Date of last endoscopy?_____ Performing physician:_____

Have you been diagnosed with one of the following conditions after an EGD:

O Barrett's Esophagus O H. pylori O Celiac Disease O Eosinophilic Esophagitis (EoE)

Past Medical History (check all that apply):

O Allergies
O Alzheimer's
O Anemia
O Anxiety
O Arthritis
O Asthma
O Atrial Fibrillation
O Autoimmune disease
O Bronchitis
O Benign Prostatic Hypertrophy
O Bleeding Disorder
O Cancer:_____
O Cataracts
O Celiac Disease
O Cellulitis
O Cerebrovascular disease
O Chronic Pain
O Chronic Kidney Disease
O Cirrhosis
O Colon Polyps
O Colon Cancer
O Congestive Heart Failure
O COPD
O Coronary Artery Disease
O Crohn's Disease
O Depression
O Diabetes Mellitus
O Diabetic Retinopathy
O Diabetic Nephropathy
O Diabetic Neuropathy
O Diverticulosis
O Eating Disorder
O Eczema
O Esophagitis
O Fatty Liver
O Fibromyalgia
O Gallbladder disease
O Gastrointestinal Bleeding
O Glaucoma
O Gout
O Heart Attack
O Heart Murmur
O Hepatitis A / B/ C
O Hemorrhoids
O Hernia
O HIV/AIDS
O H. pylori
O Hypertension
O Hyperlipidemia
O Irritable Bowel Syndrome (IBS)
O Jaundice
O Kidney Stones
O Liver Disease
O Lupus
O Memory Loss
O Microscopic colitis
O Multiple Sclerosis
O Neurological disorder
O Osteoarthritis
O Osteoporosis
O Palpitations
O Rheumatoid Arthritis
O SIBO
O Sleep Apnea
O Stroke
O Ulcerative Colitis
O Other:_____

Family History — Please list any known illnesses, cancers, or conditions:

Mother: _____	**Alive**	**Deceased**
Father: _____	**Alive**	**Deceased**
Maternal Grandmother: _____	**Alive**	**Deceased**
Maternal Grandfather: _____	**Alive**	**Deceased**
Paternal Grandmother: _____	**Alive**	**Deceased**
Paternal Grandfather: _____	**Alive**	**Deceased**
Brother: _____	**Alive**	**Deceased**
Sister: _____	**Alive**	**Deceased**

O Yes O No Do you have a first-degree relative (mother, father, sibling or child) diagnosed with any of the following conditions **before the age of 50**?

Colon or Rectal Cancer
Stomach Cancer
Cancer of the small intestine
Cancer of Bile Ducts
Pancreatic Cancer
Uterine Cancer
Ovarian Cancer
Cancer of urinary tract (kidney, ureter, bladder
Brain Cancer

O Yes O No Have you been diagnosed with any of the following conditions **before age 50**?

Colon or rectal cancer
Colon or rectal polyps

O Yes O No Do you have three or more relatives with a history of colon or rectal cancer? (This includes parents, siblings, children, grandparents, aunts/uncles and cousins.

Review of Symptoms — Please only check yes for **CURRENT** symptoms.

Gastrointestinal

Heartburn	O Yes	No O
Indigestion	O Yes	No O
Abdominal Pain	O Yes	No O
Abdominal Cramping	O Yes	No O
Constipation	O Yes	No O
Diarrhea	O Yes	No O
Bloating	O Yes	No O
Excessive Flatulence	O Yes	No O
Nausea	O Yes	No O
Vomiting	O Yes	No O
Difficulty Swallowing	O Yes	No O
Pain with swallowing	O Yes	No O
Poor Appetite	O Yes	No O
Fecal Incontinence	O Yes	No O
Black/Tarry Stools	O Yes	No O
Change in Bowel Habits	O Yes	No O
Blood in Stool	O Yes	No O
Rectal Pain or Pressure	O Yes	No O
Mucous in Stool	O Yes	No O

Ears/Nose/Eyes

Decreased Hearing	O Yes	No O
Oral Lesions	O Yes	No O
Eye Pain	O Yes	No O
Blurred Vision	O Yes	No O
Post-nasal Drip	O Yes	No O
Sinus Pain	O Yes	No O
Bloody Nose	O Yes	No O
Runny Nose	O Yes	No O
Swelling of tongue or lips	O Yes	No O

Respiratory

Wheezing	O Yes	No O
Chest Congestion	O Yes	No O
Dry Cough	O Yes	No O
Phlegm	O Yes	No O

Musculoskeletal

Joint Pain	O Yes	No O
Muscle Pain	O Yes	No O
Muscle Cramps	O Yes	No O
Swelling of Extremities	O Yes	No O

Cardiovascular

Chest Pain	O Yes	No O
Chest Pressure	O Yes	No O
Palpitations	O Yes	No O
Heart Racing	O Yes	No O
Shortness of Breath	O Yes	No O
Easy Bruising	O Yes	No O
Easy Bleeding	O Yes	No O

General

Fatigue	O Yes	No O
Fevers	O Yes	No O
Chills	O Yes	No O
Headaches	O Yes	No O
Cold Intolerance	O Yes	No O
Heat Intolerance	O Yes	No O
Memory Loss	O Yes	No O

Genitourinary

Blood in urine	O Yes	No O
Urinary Retention	O Yes	No O
Urinary Incontinence	O Yes	No O
Increased Urinary Frequency	O Yes	No O
Increased Urinary Urgency	O Yes	No O

Neurological

Depression	O Yes	No O
Anxiety	O Yes	No O
Mood Swings	O Yes	No O
Lack of Concentration	O Yes	No O
Seizures	O Yes	No O
Restlessness	O Yes	No O
Dizziness	O Yes	No O
Loss of sensation in limbs	O Yes	No O

Weight Managment

Unintentional Weight Loss	O Yes	No O
If yes, how much? ____lbs		
Time-frame? _____		
Unintentional Weight Gain	O Yes	No O
If yes, how much? ____lbs		
Time-frame? _____		
Binge Eating	O Yes	No O
Purging (all methods)	O Yes	No O