CENTER FOR GASTROINTESTINAL DISORDERS, INC.
S. SAEED ZAMANI, M.D.
Gastroenterology, Hepatology and Advanced Endoscopy
112 La Casa Via, Suite 320 Phone: (925) 939 5599
Walnut Creek, CA 94598 http://giexcellence.com Fax: (925) 939 4099

PATIENT HISTORY FORM AND INFORMATION

Patient Name	Date of Birth	Age	Gender	Referring Physician

Reason for appointment

☐ Colon cancer screening

Have you had any of the following illnesses?

___ High blood pressure
___ Pacemaker
___ Internal defibrillator (AICD)
___ Heart valve disease
___ Heart murmur
___ Arrhythmias
___ Bleeding disorder
___ Diabetes Mellitus
___ Emphysema/Chronic bronchitis
___ Asthma
___ Heart Disease
___ Taking Coumadin
___ Sleep apnea
___ Kidney disease
___ Stroke

If yes, explain: ……..
Other disorders: ……
……
……

Prior Surgeries: ……

……
……

Medications taken recently……

……
……
……
……
……

Drug allergies

☐ Not known ☐ Penicillin ☐Sulfa ☐ Morphine ☐ Demerol ☐ Fentanyl ☐Versed ☐ Valium
☐ Novocain ☐ Iodine ☐ **LATEX** ☐Others……

Social History

Occupation…… ☐ Smoking:…….. ☐ Don't smoke
Alcoholic beverages: ☐Don't drink ☐Rarely ☐Moderately ☐Illicit drugs……

Family History

	Age	Healthy	Major Health Issues	Deceased	Cause of death
Father	____	_____	_____	_____	_____
Mother	____	_____	_____	_____	_____
Brother	____	_____	_____	_____	_____
Brother	____	_____	_____	_____	_____
Sister	____	_____	_____	_____	_____
Sister	____	_____	_____	_____	_____
Sons	____	_____	_____	_____	_____
Daughters	____	_____	_____	_____	_____

Others……
……

Any family history of: ☐Colon cancer ☐Colon polyp ☐ Crohn's disease/Ulcerative colitis ☐Gastrointestinal cancers
☐Other gastrointestinal diseases ……

Please continue on reverse side….

Patient Name:_____ Date: _____

Review of Systems

Height_____Weight_____lbs.

General
___Weight loss
___Weight gain
___Chills
___Fever

Gastrointestinal (Digestive)
___Poor appetite
___Trouble swallowing
___Pain with swallowing
___Heartburn
___Regurgitation food
___Nausea
___Vomiting
___Vomiting blood
___History peptic ulcer disease
___Bloating
___Abdominal pain
___Gallbladder surgery
___Abdominal surgery
___Liver disease
___Hepatitis
___Blood transfusion
___Jaundice
___Pancreatic disease
___Diarrhea
___Constipation
___Black colored stool
___Diverticulosis
___History of colon polyp/cancer
___Blood in stool
___Mucus in stool
___Fecal incontinence
___Anal pain or itching
___Anal fissure

Any other symptoms:

Respiratory
___Frequent cough
___Wheezing
___Asthma
___Bloody sputum

Cardiovascular
___Chest pain
___Shortness of breath
___Heart attack
___High blood pressure
___Heart murmur
___Swelling feet/legs

Locomotor/Musculoskeletal
___Muscle pain
___Muscle weakness
___Joint pain
___Back pain

Genitourinary
___Urinary burning sensation
___Blood in urine
___Night time urination

Neuro-Psychiatric
___Depression
___Anxiety
___Dizziness
___Seizures
___Paralysis

Neck
___Stiffness
___Enlarged glands

Head, Eyes, ears, Nose, Throat
___Eye disease
___Headache
___Ear ache
___Impaired hearing

Hematological
___Slow to heal after the cuts
___Anemia
___Iron deficiency
___Abnormal bruising
___History of excessive bleeding after tooth extraction or surgery

Endocrine
___Hormone therapy
___Hot intolerance
___Cold intolerance
___Thyroid disease
___Diabetes

Gynecological
___Vaginal discharge
___Abnormal vaginal bleeding
___Irregular periods
___Miscarriages
___No. Pregnancies____
___1st day of last period____

Skin
___Skin disease
___Rash, hives, eczema
___Abnormal pigmentation

Signature of the patient……Date……
Source (if other than patient) ……Signature of the person acquiring this information……
May we leave a message for the results on your voice mail? ___Yes ___ No

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☐ I would like to receive a copy of any amended Notice of Privacy Practices.

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient ☐ Guardian or conservator of an incompetent patient

Your pharmacy name and address: _____
Fax: _____ Phone: _____

Patient Name: _____ Date: _____