Medoff Medical
Treating the Digestive System by Caring for the Patient

New Patient Health Record

Name_____ Date_____/_____/_____ #_____ *(office use)*

Referring MD_____ Primary MD_____

Prior GI Physicians: Name_____, M.D. Clinic_____

REASON FOR REFERRAL (*Circle the major problem you are having & describe)*

Bowel Problems _____
Nausea _____
Swallowing Problem _____
Heartburn/Reflux _____
Abdominal Pain _____
Colon Cancer Risk _____
Liver Problems _____
Other _____

Office use

MEDICAL HISTORY

Surgery:
Year_____Reason_____
Year_____Reason_____
Year_____Reason_____
Year_____Reason_____

Prior GI Tests: Colonoscopy/endoscopy_____scan/xray/other_____

Other Illness: *(list other medical conditions)*
_____ _____
_____ _____
_____ _____

Medications (include prescription drugs only):
1) _____Dose_____
2) _____Dose_____
3) _____Dose_____
4) _____Dose_____
5) _____Dose_____

*Vitamins:*_____

*Herbals:*_____

Drug allergies:
1)_____Reaction_____
2)_____Reaction_____
3)_____Reaction_____

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REVIEW OF SYSTEMS (*circle/check all of the symptoms that concern you on a frequent basis*)

Energy level: excellent good fair poor *Appetite*: excellent good fair poor

- ☐ Belching
- ☐ Hiccups
- ☐ Difficulty swallowing
- ☐ Pain with swallowing
- ☐ Heartburn
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Swelling
- ☐ Bloating
- ☐ Cramps
- ☐ Diarrhea
- ☐ Constipation
- ☐ Laxative use
- ☐ Rectal gas
- ☐ Blood in stool
- ☐ Blood on toilet paper
- ☐ Change in bowel habits
- ☐ Ribbon-like stool
- ☐ Straining
- ☐ Incomplete emptying
- ☐ Urgent bowel movements
- ☐ Accidents
- ☐ Hemorrhoids
- ☐ Rectal pain
- ☐ Loss of appetite
- ☐ Loss or gain of weight: _____lbs

- ☐ Awaken by cough, choking, or gasping
- ☐ Nose bleed
- ☐ Hoarseness
- ☐ Bad breath
- ☐ Bad taste
- ☐ Mouth sores
- ☐ Dry mouth
- ☐ Headache
- ☐ Short of breath
- ☐ Cough
- ☐ Weeze
- ☐ Asthma
- ☐ Interstitial cystitis
- ☐ Diabetes
- ☐ Painful joints: which ones?_____
- ☐ Arthritis
- ☐ What medicine do you prefer for joint pain or headaches? _____

- ☐ Nervousness
- ☐ Depression
- ☐ Psychiatrist
- ☐ Stress: on-going/temporary
- ☐ Excessive bleeding
- ☐ Anemia
- ☐ Thyroid problem

SOCIAL AND PERSONAL HISTORY

Born where_____ Greensboro since_____ Current marital status_____
Occupation_____ Company _____Retired_____*since yr*
Alcohol use: Type_____amount_____are you alcoholic_____
Tobacco use: Type_____amount_____how long_____
Education: attended/graduated : high school college grad school _____
Do you eat: milk ☐ cheese ☐ ice cream ☐ chew gum ☐ breath mints ☐ caffeine ☐ Coca Cola ☐ restrictions_____
Antibiotics (past 6 months) _____ Travel outside US (past year) _____
Religious affiliation_____active: yes no

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FAMILY HEALTH HISTORY *(Please check if there are any family members with the following:)*

Cancer:
- ☐ Esophageal
- ☐ Stomach
- ☐ Liver
- ☐ Pancreas
- ☐ Colon
- ☐ other cancer_____

Other:
- ☐ Irritable bowel (spastic colon)
- ☐ Ulcerative colitis
- ☐ Crohn's
- ☐ Ulcer
- ☐ Gallstones
- ☐ Liver disease
- ☐ Alcoholism
- ☐ Psychiatric disease
- ☐ Physical/sexual abusive behavior
- ☐ Other diseases_____

Mother: alive ☐ deceased ☐ age (at present or at time of death)_____
Father: alive ☐ deceased ☐ age (at present or at time of death)_____
Brothers: #____
Sisters: #____
Children: daughters: #_____ sons: #_____ grandchildren: #_____

Exam	Assessment	Recommendations

Office use