North Jersey Gastroenterology- Patient Encounter Form

Name:_____ DOB:___/_____/____ Age:_____

Primary or referring physician:_____ Date:_____

PHARMACY Name_____ Phone # _____

Has your address or phone number changed? Yes No □ New patient

New address: New phone number: □ Return patient

_____ Home:_____

_____ Work:_____

_____ Cell:_____

WHAT PROBLEM BRINGS YOU TO THE DOCTOR TODAY?

1. _____
2. _____

MEDICATIONS Please list the names of your current medications?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

ALLERGIES Are you allergic to any medications: 1._____ 2._____

Please circle if you allergic to: Latex Shellfish Eggs Nuts

Please circle if you have a: Cardiac pacemaker Cardiac defibrillator

HEALTH REVIEW Please circle if any of the following apply:

GENERAL: weight change, fever

SKIN: yellow skin, rashes

EYES: serious visual trouble

HEAD: headache, sore throat

LUNGS: cough, shortness of breath

HEART: chest pain, fast heart beat

URINARY: painful urination, blood in urine

MUSCLES: weakness, swelling of the legs

NEUROLOGIC: trouble walking, confusion

PAST MEDICAL HISTORY Please circle if you have a personal history of:

Diabetes	Lung disease	Vascular disease
High blood pressure	Heart disease	Other: _____
High cholesterol	Liver disease	

Have you ever had cancer? If yes, please briefly list.

1._____ 2._____ 3._____

Have you ever had an operation or surgery? If yes, please briefly list.

1._____ 2._____ 3._____

FAMILY HISTORY Please circle if you have a family history of:

Colon polyps	High cholesterol	Cancer _____
Colon cancer	Celiac sprue	Other: _____
Diabetes	Ulcerative colitis	
Heart disease	Crohn's disease	
High blood pressure	Liver disease	

SOCIAL HISTORY

Are you a current smoker? Y/ N Former smoker? Y/ N If yes, how many cigs a day? __

Do you drink alcohol? Y/N If yes, how many drinks a day? _____

What is your profession? _____

What are your hobbies? _____

Are you married? _____ Do you have children? Y/N How many? _____

FOR OFFICE USE:

BP-_____ P-_____ Weight _____ Ht-_____