GASTROCARE, P.C. AND
TUSCALOOSA ENDOSCOPY CENTER

A.B. Reddy, M.D., F.A.C.G., Henri de la Baume, M.D

Name: _____ Age: _____ Date: _____

Referring Doctor: _____

Chief Complaint: _____ Duration: _____

HPI: Abdominal Pain: (location, severity, duration, modif. Factors) Yes No

Weight Loss:	Yes	No	Vomiting:	Yes	No	Black Stool / Melena:	Yes	No
Diarrhea:	Yes	No	Blood in Vomitus:	Yes	No	Blood in Stool:	Yes	No
Constipation:	Yes	No	Heartburn:	Yes	No	Difficulty swallowing:	Yes	No
Nausea:	Yes	No	Loss of Appetite:	Yes	No			

Pertinent (Your) Past Medical History:

Cancer: Yes No Colon polyps: Yes No Peptic Ulcer: Yes No

Any other medical problems: Yes No Please list: _____

Any recent hospital admissions: Yes No

Operations: _____

Family History:

Cancer: Yes No Colon polyps: Yes No Peptic Ulcer: Yes No

Any other medical problems: Yes No Please list: _____

Social History:

Smoking: Yes No Alcohol Use: Yes No

ALLERGIES: _____

Current Medications: _____

_____

_____

ROS:

Constitutional: Appetite:		Yes	No	Weight Gain:	Yes	No	Fever:	Yes No
Cardiovascular:	Chest pain:	Yes	No	Irregular Heart:	Yes	No	Coughing up blood:	Yes No
Respiratory:	Shortness of Breath:	Yes	No	Cough:	Yes	No	Kidney stone:	Yes No
Genitourinary:	Difficulty Urinating:	Yes	No	Blood in Urine:	Yes	No		
Endocrine:	Diabetes:	Yes	No					
Psychological:	Stress Factors:	Yes	No					
Musculoskeletal:	Arthritis:	Yes	No	Lupus:	Yes	No	Fibromyalgia:	Yes No
Gynecological:	Menses: Regular / Irregular			Last Menstrual Period: _____			Endometriosis:	Yes No
CNS:								