

**NASHVILLE GASTROINTESTINAL SPECIALISTS, INC.
HISTORY AND PHYSICAL / CONSULT**

Date: _____

LAST NAME	FIRST	NAME YOU PREFER	MIDDLE INITIAL	SEX: M ___ F ___	AGE	DATE OF BIRTH:
------------------	--------------	------------------------	-----------------------	----------------------------	------------	-----------------------

Occupation: _____ Retired: Y/N	# Dependents _____ WT _____ HT _____	Marital Status: S ___ M ___ D ___ W ___	Stress Level on Job: Score 0-10: _____ Level of personal/family stress: Score 0-10: _____
-----------------------------------	---	--	--

REFERRAL SOURCE: Physician: _____ Other Source: _____
Other Doctors You See: _____

LIST ALLERGIES TO MEDICATIONS (NAME OF MEDICATION AND REACTION):
 1. _____ 2. _____ 3. _____

CHIEF COMPLAINT: What is the main reason you are here today? _____
 Have you had any recent x-rays pertaining to the reason you are here today? Yes ___ No ___ If yes, please explain
 Have you had any recent lab tests pertaining to the reason you are here today? Yes ___ No ___ If yes, please explain

PRESENT ILLNESS:
 Symptom: _____
 Onset: _____
 Location: _____
 Severity: _____
 Timing: _____
 What Makes Better: _____ WORSE: _____

PRESENT MEDICAL ILLNESSES: Do you have a problem with any of these <u>now</u> ? Please answer all questions.											
	YES	NO	COMMENTS		YES	NO	COMMENTS		YES	NO	COMMENTS
Heartburn				Diarrhea				Weight Loss			# of pounds _____
Difficulty swallowing			Solids ___ Liquids ___ Both ___	Abdominal Pain				Change in BMs (frequency/color)			
Yellow Skin				Constipation				Fever			
Nausea				Vomiting				Loss of appetite			
Rectal bleeding				Black, Tarry Stools				Do any foods worsen symptoms			
Vomiting blood			How often? _____	Anal Pain with BMs				Bloating/Excessive Gas			

PAST MEDICAL HISTORY: DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK THE APPROPRIATE BOX.									
	Yes	No		Yes	No		Yes	No	
blood transfusions			chest pain			free bleeder, i.e. hemophilia			
heart disease			diabetes			kidney problems			
breathing problems			ulcers			sleep apnea			
asthma			liver problems			high blood pressure			
seizure disorder			hepatitis			cancer (if yes, list)			
damaged/replaced heart valve			mitral valve prolapse			rheumatic fever			

PAST SURGICAL HISTORY: SURGICAL ILLNESSES
 Have you ever had any surgeries? **YES/NO** IF YES, PLEASE LIST SURGERY OR PROCEDURE BELOW AND SPECIFY YEAR DONE:

Are your immunizations up-to-date? (Tetanus, hepatitis B, flu, pneumonia) **YES/NO**

<p>SOCIAL HISTORY - Do you use any of the following? Alcohol YES/NO amount per week: _____ Cigarettes YES/NO pkg/day or amount: _____</p>	<p>Caffeine/Cola YES/NO cups/day: _____ Drug Use (marijuana, etc.) YES/NO Type: _____ Have you traveled outside the U.S. in the past year? Where: _____</p>
--	---

FAMILY MEDICAL PROBLEMS/CAUSES OF DEATH:
Mother: _____ **Brother/Sisters:** _____
Father: _____ **Children:** _____

FAMILY MEDICAL HISTORY Immediate family refers to blood relatives only, not relatives by marriage. This does **NOT** apply to YOU.

DISEASE	YES	NO	WHO	DISEASE	YES	NO	WHO	DISEASE	YES	NO	WHO
Liver disease				Spastic colon (irritable bowel)				Colon polyps			
Stroke				Anesthesia Complications				Crohn's Disease			
Ulcers				Colon Cancer				Ulcerative Colitis			
Diabetes				Tuberculosis				Cancer			
Asthma											

PLEASE LIST MEDICINES AND DOSAGES YOU ARE TAKING, PLEASE INCLUDE OVER-THE-COUNTER MEDS, HERBS, VITAMINS, ETC.

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

ANTI-INFLAMMATORY DRUGS: In the last month, have you taken aspirin or aspirin-like drugs such as ibuprofen, Nuprin, Advil, Aleve, BC powders, Goody's powders, Alka- Seltzer, or Anacin? If yes, circle the drug. Others: _____

DO YOU HAVE ANY OF THE FOLLOWING? PLEASE CHECK THE APPROPRIATE BOX.

REVIEW OF SYSTEMS	YES	NO	REVIEW OF SYSTEMS	YES	NO	REVIEW OF SYSTEMS	YES	NO	REVIEW OF SYSTEMS	YES	NO
Change in weight			Sore throat			Difficulty swallowing			Arm/leg weakness		
Fatigue			Shortness of breath			Rectal bleeding			Arthritis/back pain		
Skin changes			Asthma			Nausea			Anemia/blood disorder		
Rash			High cholesterol			Food allergies			Thyroid problems		
Frequent headaches			High blood pressure			Bowel incontinence			Nervousness/depression		
Hoarseness			Vomiting			Blood in urine					

PHYSICAL EXAM (TO BE COMPLETED BY PHYSICIAN)

CONSTITUTIONAL	VS: WT: _____ R: _____ P: _____ BP: _____ Temp: _____	WNL	ND	COMMENTS
GENERAL	NAD; WDN.			
EYES	Sclerae anicteric. PERRLA.			
NECK	Without masses. Thyroid symmetric. Non-enlarged.			
RESPIRATORY	Respiratory effort is normal. Breath sounds clear to auscultation.			
CV	Heart RRR. No murmurs, rubs, or gallops.			
ABDOMEN	Soft, no tenderness to palpation, no hsm, no guarding, no rebound, no masses, no inguinal hernias.			
RECTAL	No fissures/fistulas, no external hemorrhoids, no hemorrhoidal tags, heme negative			
LYMPH	No neck, supraclavicular, axillae, groin nodes palpable. No nodal tenderness.			
SKIN	No rash, lesions, jaundice			
PSYCHIATRIC	Normal orientation, memory. (Mood/ Depression)			
MUSCULO-SKELETAL	Normal gait. Strength is equal. Normal range of motion.			
NEUROLOGIC	Cranial nerves II-XII grossly intact. Normal sensation/reflexes.			

Labs Reviewed: _____ Old Records Reviewed: Yes/No. Time Spent Counseling _____

Anesthesia Class of Physical Status: ___ Class I: No systemic illness. ___ Class II: Mild to moderately severe systemic illness. ___ Class III: Severe systemic illness. ___ Class IV: Life-threatening illness. ___ Class V: Moribund patient. **Anesthesia Plan:** Patient will be sedated with a benzodiazepine and a narcotic such that protective reflexes are maintained. A preoperative oral dose of a barbiturate may be given. **Informed Consent:** The nature, alternatives, indications, risks, and plan for conscious sedation and the above procedure(s) were discussed with the patient and/or guardian and questions were answered. The patient and/or guardian verbalized an understanding and agreed to undergo the procedure.

M.D. Signature: _____ **Date:** _____