GASTROENTEROLOGY CLINIC
THE IOWA CLINIC

Name:_____ **Age:** _____ **DOB:** _____

REVIEW OF SYSTEMS – Check Yes or No for *current* symptoms

	YES	NO		YES	NO
Nausea			Cough		
Vomiting			Shortness of breath		
Difficulty swallowing			Pain with breathing		
Abdominal Pain			Chest pain		
Diarrhea			Palpitations of the heart (racing, skipped beats)		
Constipation			Ankle swelling		
Change in bowel habit			Pain or burning with urination		
Red blood **on** bowel movement			Blood in the urine		
Red blood **in** bowel movement			Awakening to urinate 2 or more times a night		
Black, tarry stools			Joint pain		
Jaundice			Joint swelling		
Loss of appetite			Muscle pain		
Fatigue/Lethargy			Muscle weakness		
Weight loss			Change in hair texture		
Weight gain			Change in nails		
Fever			Change in menstrual period		
Chills			Intolerance to heat		
Eye pain or inflammation			Intolerance to cold		
Loss of vision			Vertigo or dizziness		
Sinus pain			Numbness		
Nose bleeds			Tingling		
Sores in the mouth			Tremor		
Dental abscess			Double vision		
Skin rash			Blue mood/depression		
Itching			Anxiety/nervousness		
Open sores or tender lumps on skin			Irritability		
Swollen lymph glands			Loss of interest/apathy		
Easy bruising					

Medication Allergies (Please list with adverse reaction)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Current Medications (Please list all medications and dosage)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

PERSONAL PAST MEDICAL HISTORY

Medical Illnesses (check Yes or No) If Yes, Date of Onset, Comments

Crohn's Disease	Yes ☐ No ☐	_____
Ulcerative Colitis	Yes ☐ No ☐	_____
Liver Disease	Yes ☐ No ☐	_____
Gallstones	Yes ☐ No ☐	_____
Peptic Ulcer	Yes ☐ No ☐	_____
Bleeding	Yes ☐ No ☐	_____
Colon Polyps	Yes ☐ No ☐	_____
Colon Cancer	Yes ☐ No ☐	_____
Diabetes	Yes ☐ No ☐	_____
Heart Disease	Yes ☐ No ☐	_____
Hypertension	Yes ☐ No ☐	_____
Stroke	Yes ☐ No ☐	_____
Lung Disease	Yes ☐ No ☐	_____
Glaucoma	Yes ☐ No ☐	_____

Past Surgical History (List all operations and approximate dates)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HISTORY – Please indicate any relatives with a history of:

Number of Children				
Crohn's Disease				
Ulcerative Colitis				
Colon or rectal polyps				
Colon cancer				
Hemochromatosis				
Alcoholism				
Gallstones				
Liver disease (chronic hepatitis, cirrhosis, jaundice)				
Diabetes				
Hypertension (high blood pressure)				
Heart Disease				
Other significant hereditary illness				

PERSONAL HISTORY

Habits (Past or Currently) (Check Yes or No)

Tobacco Yes ☐ No ☐ Duration and Amount _____

Alcohol Yes ☐ No ☐ Duration and Amount _____

Coffee/Caffeine Yes ☐ No ☐ Amount _____

Occupation_____ **Marital Status** _____

Recent Travel Outside USA_____

Immunizations/Vaccinations (Check Yes or No) If yes, what year?

Hepatitis A Yes ☐ No ☐ _____ Hepatitis B Yes ☐ No ☐ _____ Pneumonia Yes ☐ No ☐ _____

Tetanus Yes ☐ No ☐ _____ Influenza Yes ☐ No ☐ _____