**Raleigh/Cary Medical Group GI – Wake, Clayton, Wake Forest, and Wilson Endoscopy Centers**

**Patient History and Physical Form**

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chart No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***Please, complete both sides prior to arrival***.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GI Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present Problem\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight\_\_\_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_\_\_\_ BMI: \_\_\_\_\_\_\_\_\_\_\_ Pregnant Yes / No

Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Translator needed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Includes Hearing Impaired)

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred method of contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Personal Health History***

\_\_\_\_ Diabetes \_\_\_\_ COPD \_\_\_\_ Seizures

\_\_\_\_ Stroke \_\_\_\_ Emphysema \_\_\_\_ Last Seizure

\_\_\_\_ Cardiac Stents \_\_yrs. \_\_\_\_ Asthma \_\_\_\_ Seizure Stimulator

\_\_\_\_ Heart Failure \_\_\_\_ Inhalers Y/N \_\_\_\_ Parkinson’s

\_\_\_\_ Heart Attack \_\_\_\_ Sleep Apnea CPAP Y/N \_\_\_\_ Muscular Dystrophy

\_\_\_\_ Heart Bypass x\_\_\_ \_\_\_\_ Home Oxygen \_\_\_\_ Alzheimer’s

\_\_\_\_ Pacemaker \_\_\_\_ High Blood Pressure \_\_\_\_ Migraines

\_\_\_\_ Defibrillator \_\_\_\_ Reflux \_\_\_\_ Depression

\_\_\_\_ Heart Catheterization \_\_\_\_ Bleeding Disorder \_\_\_\_ Anxiety

\_\_\_\_ Irregular Heart Beat \_\_\_\_ Ulcers \_\_\_\_ Kidney Disease

\_\_\_\_ Angina \_\_\_\_ Liver Disease \_\_\_\_ Dialysis

\_\_\_\_ Blocked Arteries \_\_\_\_ Hepatitis A/B/C \_\_\_\_ Crohn’s Disease

\_\_\_\_ Heart Valve Replaced \_\_\_\_ Cirrhosis/encephalopathy \_\_\_\_ Colitis

\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Ascites (Fluid in Abd.) \_\_\_\_ Joint Replacement

Past complications with sedation: No / Yes List Complications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fear of Needles: No / Yes Difficulty obtaining IVs No / Yes

Do you currently smoke: No / Yes # packs/day\_\_\_\_\_ Former Smoker: No / Yes

Recreational Drugs: No / Yes \_\_\_\_\_\_\_ Drink alcohol: No / Yes Socially \_\_\_\_\_\_ Amount \_\_\_\_\_\_\_\_\_\_\_\_

Immunizations: Flu vaccine No / Yes \_\_\_\_\_\_\_ Pneumonia vaccine No / Yes \_\_\_\_\_\_\_\_\_\_\_

Covid-19 vaccine No / Yes\_\_\_\_\_\_\_\_ Booster No / Yes\_\_\_\_\_\_\_\_

Surgeries\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disabilities/Immobility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colonoscopy No / Yes \_\_\_\_\_date; Upper Endoscopy No / Yes \_\_\_\_\_ date; Mammogram No / Yes

\_\_\_\_date

History of polyps: Self: No / Yes \_\_\_age; \_\_\_ Family No/ Yes \_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_age

***Personal or family history of: (list self or relationship of family member and age)***

Colorectal Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stomach /Esophageal Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Kidney /Ureter Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Endometrial/Uterine/Ovarian \_\_\_\_\_\_\_\_\_\_\_\_ Pancreatic/Biliary Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Small Bowel Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Brain/Sebaceous Adenomas \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chart: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Latex allergy: No / Yes Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergy to eggs or soy beans: No / Yes Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**: Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Present Medications: (List over the counter and Herbal Meds also)**

**CURRENT PHARMACY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_**

**Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_**

**Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_**

**Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_**

**Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_**

**Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_**

**Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_**

**Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_**

**Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_**

**Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_**

**Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_**

**Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_**

**Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_**

**Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_**

**Hx./Medications Reviewed by Endo Nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Revised S Parrish RN 12/03/2021