North Suburban Gastroenterology Associates, SC

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Review of Systems, Personal History and Family History

Patient Name: _____ Date of birth: _____

Today's Date: _____ Occupation: _____

Reason for visit:

a. **Schedule a SCREENING COLONOSCOPY** ☐ **YES** ☐ **NO**
b. _____
c. _____
d. _____

Other Medical Conditions:

a. _____
b. _____
c. _____
d. _____

Surgery/Year: _____

_____

Please list ALL MEDICATIONS you are taking, as well as all medications you may be ALLERGIC to on our "Medication Flowsheet"

Personal History of:

☐ Cancer ☐ Polyps ☐ Ulcer ☐ Liver Disease ☐ Pancreatitis

Family History of:

☐ Cancer ☐ Polyps ☐ Ulcer ☐ Liver Disease ☐ Pancreatitis

Note any illnesses; if deceased, give age and cause of death:

Father: _____

Mother: _____

Brothers/Sisters: _____

Children: _____

Spouse: _____

Do you smoke? ___ NO ___ YES

Number of packs per day _____

Number of years smoked _____

Do you use alcohol? ___ NO ___ YES

Number of drinks per week _____

Number of years drinking _____

Reviewed by _____ Date _____

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Review of Systems, Personal History and Family History – page 2 of 2

for Patient:

Constitutional

Recent weight change	___ No	___ Yes
Fever	___ No	___ Yes
Fatigue	___ No	___ Yes
Malaise	___ No	___ Yes

Eyes

Blurred vision	___ No	___ Yes
History of Glaucoma	___ No	___ Yes

Ears-Nose-Mouth-Throat

Earache	___ No	___ Yes
Hearing loss	___ No	___ Yes
Ringing in ears	___ No	___ Yes
Mouth sores	___ No	___ Yes
Nasal discharge	___ No	___ Yes
Throat pain	___ No	___ Yes

Cardiovascular

Chest pain or discomfort	___ No	___ Yes
Fast heart rate or palpitations	___ No	___ Yes
Swelling of ankles	___ No	___ Yes

Respiratory

Chronic cough	___ No	___ Yes
Spitting up blood	___ No	___ Yes
Shortness of breath	___ No	___ Yes
Wheezing	___ No	___ Yes
Snoring	___ No	___ Yes
Sleep Apnea	___ No	___ Yes

Genitourinary

Burning during urination	___ No	___ Yes
Blood in urine	___ No	___ Yes
Increased urinary frequency	___ No	___ Yes

Musculoskeletal

Joint pain, localized	___ No	___ Yes
Joint swelling, localized	___ No	___ Yes
Back pain	___ No	___ Yes
Muscle pain	___ No	___ Yes

Skin

Itching	___ No	___ Yes
Rashes	___ No	___ Yes

Comments:

Gastrointestinal

Poor/decreased appetite	___ No	___ Yes
Difficulty in swallowing	___ No	___ Yes
Heartburn	___ No	___ Yes
Nausea	___ No	___ Yes
Vomiting	___ No	___ Yes
Bloating	___ No	___ Yes
Belching	___ No	___ Yes
Regurgitation	___ No	___ Yes
Constipation	___ No	___ Yes
Diarrhea	___ No	___ Yes
Abdominal pain	___ No	___ Yes
Change in bowel habits	___ No	___ Yes
Red blood in bowel movement	___ No	___ Yes
Black or bloody stools	___ No	___ Yes
Bowel movement frequency	___ No	___ Yes
Bowel urgency	___ No	___ Yes
Anemia-*if Y bring labs*	___ No	___ Yes

Neurological

Headaches	___ No	___ Yes
Convulsions/seizures	___ No	___ Yes
Numbness	___ No	___ Yes
Motor disturbances	___ No	___ Yes
Strokes	___ No	___ Yes

Psychological

Memory loss or confusion	___ No	___ Yes
Confused/disoriented	___ No	___ Yes
Depression	___ No	___ Yes
Anxiety	___ No	___ Yes

Endocrine

Heat intolerance, consistent	___ No	___ Yes
Cold intolerance, consistent	___ No	___ Yes

Hematological

Easy bleeding	___ No	___ Yes
Bruising tendency	___ No	___ Yes
Past transfusion	___ No	___ Yes

Are you pregnant? ___ No ___ Yes

Reviewed by _____ Date _____