GASTROENTEROLOGY ASSOCIATES OF CENTRAL JERSEY, P.A.

Patient Information Sheet

PATIENT NAME: MARITAL STATUS □ single □divorced □married □widow/widower

DATE OF BIRTH: Primary Care Physician:

PLEASE CHECK BOX IF YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS:

- □ Heartburn
- □ Nausea
- □ Vomiting
- □ Abdominal pain
- □ Constipation
- □ Diarrhea
- □ Stool leakage
- □ Rectal bleeding
- □ Difficulty swallowing
- □ Blood in stool
- □ Change in bowel habit
- □ Colon polyps
- □ Irritable Bowel Syndrome
- □ Crohn's Disease
- □ Ulcerative colitis
- □ Liver disease
- □ Hepatitis
- □ Pancreatitis

PAST HISTORY:

Are you currently or have you ever used tobacco or alcohol products? YES □ NO□ If yes:

Alcohol: How many drinks: ___socially only ____daily ____weekly ____monthly

Tobacco: How many packs per day? __ pks For how many years: __ If you quit, what year? ___

Do you have any allergies: YES □ NO □ If Yes, please list below and the reaction:

Do you have any family history of colon, esophageal, stomach, liver, or pancreatic cancer? If YES, please list below which family member, which age they were diagnosed:

Confidentiality of this medial record shall be maintained except when use or disclosure is required or permitted by law, regulations, or written authorization by the patient.

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FOR OFFICE STAFF ONLY:

VITALS:

Blood pressure: _____/_____

Pulse: _____

Height: _____

Weight: _____lbs.

REASON FOR VISIT:

CURRENT MEDICATION:

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