320 Lillington Ave
Suite 101
Charlotte, NC 28204-3189

Phone: 704.362.4403
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Please fill out the following form completely so that we may obtain the necessary information for our files and background information on your medical problem. In this way, more time will be available for you to talk to the doctor at the time of your visit. All information is held in strict confidence and will NOT be released to anyone without your written consent.

PATIENT INFORMATION (Please print all information) Date: ____

Referring Physician: ________________________ Phone Number: ________________________________

Primary Care Physician: ____________________________ Phone Number: ________________________________

Name: ____ Date of Birth: __________________ Age: __________

Mailing Address: ____ Sex: _______ Race: ____________

Home Phone: __________________________ Cell Phone: __________________ SSN: ________________________

Occupation: ____________________________ Employer: ___________________ Work Phone: __________________

Emergency Contact Person: ________________________ Relationship: _________________ Phone: _______________

E-mail Address: ____

ALLERGIES: Please list any allergies that you have and your reaction:

____

____

FAMILY HISTORY ONLY: Please circle yes or no for each item for family members only. If yes, please indicate their relationship to you on the line provided.

			Relationship				Relationship
Anemia	Yes	No	____________	Gallstones	Yes	No	_________
Breast Cancer	Yes	No	____________	Heart Disease	Yes	No	_________
Celiac Disease	Yes	No	____________	Hemochromatosis	Yes	No	_________
Cervical Cancer	Yes	No	____________	Hepatitis C	Yes	No	_________
Cirrhosis of Liver	Yes	No	____________	Irritable Bowel Syndrome	Yes	No	_________
Colon Cancer	Yes	No	____________	Ovarian Cancer	Yes	No	_________
Colon Polyps	Yes	No	____________	Pancreatic Cancer	Yes	No	_________
Crohn's Disease	Yes	No	____________	Pancreatitis	Yes	No	_________
Diabetes	Yes	No	____________	Peptic Ulcer Disease	Yes	No	_________
Esophageal Cancer	Yes	No	____________	Ulcerative Colitis	Yes	No	_________
Gastric Cancer	Yes	No	____________	Uterine Cancer	Yes	No	_________
Reaction to anesthesia	Yes	No	____________				

YOUR PAST MEDICAL HISTORY: Please circle yes or no for each item for **yourself only.**

CANCER

Breast Cancer	Yes	No
Cervical Cancer	Yes	No
Colon Cancer	Yes	No
Esophageal Cancer	Yes	No
Leukemia	Yes	No
Liver Cancer	Yes	No
Lymphoma	Yes	No
Ovarian Cancer	Yes	No
Pancreatic Cancer	Yes	No
Prostate Cancer	Yes	No
Stomach Cancer	Yes	No
Uterine Cancer	Yes	No

RENAL

Dialysis	Yes	No
Kidney Failure	Yes	No

MUSCULOESKELETAL

Fibromyalgia	Yes	No
Gout	Yes	No
Lupus	Yes	No
OsteoArthritis	Yes	No
Osteoporosis	Yes	No
Reynaud's	Yes	No
Rheumatoid Arthritis	Yes	No
Scleroderma	Yes	No
Sjogrens	Yes	No

PSYCHOLOGICAL

Anxiety	Yes	No
Bipolar	Yes	No
Depression	Yes	No
Obsessive Compulsive Disorder	Yes	No
Esquisofrenia	Yes	No

LIVER

Cirrhosis	Yes	No
Fatty Liver	Yes	No
Hemochromatosis	Yes	No
Hepatitis A	Yes	No
Hepatitis B	Yes	No
Hepatitis C	Yes	No
Jaundice	yes	No

HEART

Congestive Heart Failure	Yes	No
Endocarditis	Yes	No
Heart Attack (Myocardial Infarction)	Yes	No
Heart Valve Disease	Yes	No

HEART (continuation)

High Blood Pressure	Yes	No
Mitral Valve Prolapse	Yes	No
Palpitations	Yes	No
Rheumatic Fever	Yes	No
Pacemaker	Yes	No

BLOOD

Anemia	Yes	No
Bleeding or clotting abnormalities	Yes	No
Hemophilia	Yes	No
VonWillebrands'	Yes	No
HIV / AIDS	Yes	No

INTEGUMENTARY

Eczema	Yes	No
Melanoma	Yes	No
Psoriasis	Yes	No

NEUROLOGICAL

Alzheimer/Dementia	Yes	No
Brain Aneurysm	Yes	No
Migraines	Yes	No
Myasthenia Gravis	Yes	No
Seizures	Yes	No
Stroke	Yes	No

RESPIRATORY

Asthma	Yes	No
COPD (Emphysema)	Yes	No
Sleep Apnea	Yes	No
Tuberculosis (TB)	Yes	No

GASTROINTESTINAL

Angiodysplasia of GI Tract	Yes	No
Barrett's Esophagus	Yes	No
Celiac Disease	Yes	No
Colon Plyps	Yes	No
Crohn's Disease	Yes	No
Diverticulitis	Yes	No
Diverticulosis	Yes	No
Hemorrhoids	Yes	No
IBS (Irritable Bowel Syndrome)	Yes	No
Pancreatitis	Yes	No
Peptic Ulcer Disease	Yes	No
Reflux	Yes	No
Ulcerative Colitis	Yes	No

ENDOCRINOLOGY

Diabetes, Type I (insulin needed)	Yes	No
Diabetes, Type II (pills needed)	Yes	No
Thyroid Disease	Yes	No

SURGERIES: Please circle yes or no for each item **for yourself** only. If yes, please indicate the date on the line provided.

GASTROINTESTINAL

			Month / Year
Appendectomy	Yes	No	_____________
Capsule Endoscopy	Yes	No	_____________
Cholecystectomy (Gallbladder Removal)	Yes	No	_____________
Colon Surgery	Yes	No	______________
Colonoscopy	Yes	No	______________
ERCP	Yes	No	______________
EUS	Yes	No	______________
Gastric Bypass	Yes	No	______________
Gastric Surgery	Yes	No	______________
Hiatal Hernia Repair	Yes	No	______________
Inguinal Hernia	Yes	No	______________
Manometry	Yes	No	______________
Pancreatic Surgery	Yes	No	______________
PEG Tube Placement	Yes	No	______________
Esplenectomy (removal of spleen)	Yes	No	______________
Surgery for Intestinal Adhesions	Yes	No	______________
Umbilical Hernia	Yes	No	______________
Upper Endoscopy (EGD)	Yes	No	______________

GYNECOLOGICAL

C-Section	Yes	No
Hysterectomy (Abdominal)	Yes	No
Hysterectomy (Vaginal)	Yes	No
Mastectomy (right)	Yes	No
Mastectomy (left)	Yes	No
Mastectomia (both)	Yes	No
Ovary Removal (right)	Yes	No
Ovary Removal (left)	Yes	No
Ovary Removal (both)	Yes	No

GU

			Month / Yr
Bladder Surgery	Yes	No	___________
Cystectomy with Ileal Conduit	Yes	No	___________
Kidney Removal (nephrectomy)	Yes	No	___________
Prostate Removal (Prostatectomy)	Yes	No	___________
Radiation for Prostate Cancer	Yes	No	___________
TURP	Yes	No	___________

CARDIAC

Abdominal Aneurysm	Yes	No	___________
Angioplasty	Yes	No	___________
CABG (Coronary Bypass)	Yes	No	___________
Cardiac Catherization	Yes	No	___________
FemPop bypass (Leg Arteries)	Yes	No	___________
Heart Stent placed	Yes	No	___________
Heart Valve Replacement	Yes	No	___________
Pacemaker	Yes	No	___________
Defibrillator	Yes	No	___________

OTHER

_________________________ ______
_________________________ ______
_________________________ ______
_________________________ ______

Have you ever had a complication to Anesthesia?
YES **NO**

SOCIAL HISTORY:

Marital Status: Married Single Widow Divorced ______________________

Use of Tobacco:
___ No history of tobacco use
___ History of tobacco use
___ Packs per day
___ Years of use
___ Year quit

Use of Alcohol:
___ No History of alcohol use
___ History of alcohol use
___ Glasses daily
___ Glasses weekly
___ Glasses occasional
___ History of alcoholism

Use of Drugs:
___ No History of drug use
___ History of drug use
___ IV drug abuse
___ Marijuana
___ Crack/Cocaine
___ Year quit

REVIEW OF SYSTEMS: Please circle yes for each symptom or disease diagnosed for you during the last 2 months. Circle no for all others.

GENERAL

Loss of Appetite/Anorexia	Yes	No
Fatigue	Yes	No
Fever	Yes	No
Night Sweats	Yes	No
Weight Gain in the last 3 months Amount _________	Yes	No
Weight loss in the last 3 months Amount _________	Yes	No
Are you under any stress?	Yes	No
Eye pain	Yes	No

SKIN

Skin Rash	Yes	No

ENT

Hoarseness	Yes	No
Oral Ulcers	Yes	No
Voice changes	Yes	No
Headache	Yes	No
Vision Problems	Yes	No
Loss of visión	Yes	No
Double vision	Yes	No
Blurred vision	Yes	No

HEMATOLOGY

Enlarged Lymph Nodes	Yes	No
Prolonged Bleeding	Yes	No

GENITOURINARY

Blood in urine	Yes	No
Painful urination	Yes	No

RESPIRATORY

Cough	Yes	No
Shortness of breath	Yes	No
Wheezing	Yes	No

CARDIOVASCULAR

Chest pain	Yes	No
Edema/ swelling	Yes	No
Difficulty breathing while laying down	Yes	No
Palpitations	Yes	No
Shortness of breath	Yes	No

NEUROLOGICAL

Incontinence Stool	Yes	No
Numbness	Yes	No
Weakness	Yes	No

GASTROINTESTINAL

Frequent constipation	Yes	No
Pain with bowel movement	Yes	No
Pale, greasy, oily, or rancid stools	Yes	No
Mucus in or on your stool	Yes	No
Frequent diarrhea	Yes	No
Black or sticky stools	Yes	No
Blood in or on your stools	Yes	No
Vomit frequently	Yes	No
Vomit blood or “coffee grounds”	Yes	No
Bloating, belching, or excessive gas	Yes	No
Difficult or painful swallowing	Yes	No
Frequent heartburn or indigestion	Yes	No
Frequent stomach pain	Yes	No
Recent changes in your bowel movement	Yes	No
Jaundice (yellow eyes)	Yes	No

PATIENT MEDICATION LIST

Please print! Medication list should include all over-the-counter and taken-as-needed medications.

Local Pharmacy: ___________________________________ ______ Location: __________________________________

Mail Order Pharmacy: _____________________________________

Medication Name	Strength (mg)	Number of Times Taken Daily	Reason