WELCOME TO THE GASTROENTEROLOGY AND HEPATOLOGY CLINIC!

We are located at:
Valley Specialty Center, 5th floor (Suite 540)
751 South Bascom Avenue
San Jose, CA 95128
Tel: 408-793-2550
Fax: 408-885-7999

If you need to reschedule or cancel your appointment, please call us or cancel via MyHealth Online at least 24 hours before your appointment time.

IMPORTANT

Please fill out this form completely and bring it with you to your appointment.

Please also bring all your medications, including over the counter medications, in their original bottles.
1. What is the most important problem you wish to discuss in clinic?

2. Allergies: Please list name of medication and the reaction you have. Also list any allergies to iodine, radiology contrast, etc.

3. Procedure and sedation issues
   - Have you ever had a bad reaction to anesthesia or sedation (such as trouble waking up afterwards)?  
     - O Yes  O No
   - Do you have a history of bleeding after dental work or other procedures?  
     - O Yes  O No
   - Do you use supplemental oxygen at home?  
     - O Yes  O No
   - Do you use a machine to help you breathe at night (such as a CPAP machine)?  
     - O Yes  O No
   - Do you use any recreational drugs? (please provide details in Section 13)  
     - O Yes  O No

4. Medications: Please list names, doses, and number of times per day. Please include over-the-counter medicines (such as Tylenol, Motrin, Aleve, ibuprofen, antacids, etc.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Times/day</th>
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<tbody>
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</tbody>
</table>

5. Preferred Pharmacy
   - □ Valley Specialty Center
   - □ East Valley
   - □ Milpitas
   - □ Bascom
   - □ Gilroy
   - □ Moorpark
   - □ Downtown
   - □ Lenzen
   - □ Sunnyvale
   - □ Tully
   - □ Other (specify name and location): ________________________________________________________________
6. Do you have abdominal pain?  

- Yes  
- No (please skip to the next section)

Please indicate with an “X” where the pain is located:

On a scale of 1-10, how bad is the pain on an average day?

1 2 3 4 5 6 7 8 9 10

How would you describe the pain?

- Burning  
- Stabbing  
- Cramping  
- Aching  
- Other (specify)

How long have you had the pain?

How often do you get the pain?

How long does the pain last?

What affects the pain?

- Eating
- Bowel movement
- Stress
- Antacids
- Other (specify)

Better  
Worse  
No change

0 0 0

7. Do you have any of these other GI symptoms? Please check all that apply.

- Difficult or painful swallowing
- Bloating
- Vomiting blood
- Nausea
- Constipation
- Black stools
- Vomiting
- Diarrhea
- Jaundice (yellow eyes or skin)
- Heartburn
- Incontinence/ leakage of stool
- Other (specify)
- Excessive passage of gas
- Blood from the rectum

8. Prior GI Evaluation

Have you seen a gastroenterologist (stomach, colon, or liver specialist) in the past?

- Yes  
- No

If Yes, name and address of gastroenterologist:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Date</th>
<th>Clinic or Hospital Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper endoscopy (EGD)</td>
<td></td>
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<tr>
<td>Colonoscopy</td>
<td></td>
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<tr>
<td>Sigmoidoscopy</td>
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<tr>
<td>Liver Biopsy</td>
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<tr>
<td>Other (specify):</td>
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</tr>
</tbody>
</table>
### 9. Past Medical History: please mark any medical problems you have had, past or present.

- O Alcohol abuse
- O Anal fissure
- O Anemia
- O Arthritis
- O Asthma
- O Atrial fibrillation
- O Barrett’s Esophagus
- O Blood clots
- O Celiac disease
- O Constipation
- O Cirrhosis
- O Colon cancer
- O Colon polyps
- O Crohn’s Disease
- O Depression/Anxiety
- O Diarrhea
- O Diabetes
- O Diverticulitis
- O Diverticulosis
- O Heart disease/Heart attack/Heart stent
- O H. pylori infection
- O Headaches
- O Heartburn
- O Heart disease/Heart attack/Heart stent
- O Hemochromatosis
- O Hemorrhoids
- O Hepatitis B
- O Hepatitis C
- O Hepatitis (specify___________)
- O Hernia (specify___________)
- O Hiatal hernia
- O HIV or AIDS
- O Immune system problems
- O Inflammatory Bowel Disease (IBD)
- O Irritable bowel syndrome (IBS)
- O Esophageal varices
- O Fatty Liver
- O Fibromyalgia
- O Gallstones
- O Heartburn
- O Kidney disease/renal failure
- O Liver cancer
- O Lung disease/COPD
- O Pacemaker or Defibrillator
- O Pancreatitis
- O Pancreatic cancer
- O Psychiatric disease/Bipolar disorder
- O Sleep apnea
- O Stomach/Intestinal ulcers
- O Stomach polyps
- O Stomach cancer
- O Thyroid problems
- O Ulcerative Colitis
- O Other (specify below)

### 10. Past Surgical History

- O Appendectomy
- O Bowel obstruction surgery
- O C-section
- O Colon surgery
- O Esophagus surgery
- O Feeding tube placement (PEG)
- O Gallbladder surgery
- O Gastric bypass or banding
- O Gynecologic surgery
- O Heart bypass surgery
- O Heart valve surgery
- O Hernia repair
- O Liver surgery
- O Pancreas surgery
- O Small intestine surgery
- O Stomach surgery
- O Tubal ligation
- O Other surgery (specify below)

### 11. Prior hospitalizations: please list most recent ones first

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Problem</th>
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<tbody>
<tr>
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</table>
12. Family history: Please indicate if any of your family members have or had any medical problems

<table>
<thead>
<tr>
<th></th>
<th>Colon cancer</th>
<th>Colon polyps</th>
<th>Stomach cancer</th>
<th>Liver cancer</th>
<th>Pancreas cancer</th>
<th>GYN or GU cancer</th>
<th>Colitis/IBD</th>
<th>Celiac disease</th>
<th>Liver disease</th>
<th>Other medical problems (specify)</th>
<th>Currently alive?</th>
<th>Age at death</th>
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<tbody>
<tr>
<td>Father</td>
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<td>0</td>
<td>0</td>
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<td>O Y O N</td>
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<tr>
<td>Mother</td>
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<td>Brother(s)</td>
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<tr>
<td>Sister(s)</td>
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<td>O Y O N</td>
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<tr>
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13. Social History

Place of birth ____________________________

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<thead>
<tr>
<th>Substance use</th>
<th>Current</th>
<th>Former</th>
<th>Never</th>
<th>Date started</th>
<th>Date of most recent use</th>
<th>How often do you use?</th>
<th>How much do you use?</th>
<th>Ready to quit?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wine</td>
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<tr>
<td>Beer</td>
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<td>Hard Liquor</td>
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<td>Other tobacco</td>
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<tr>
<td>Marijuana</td>
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<tr>
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<tr>
<td>Cocaine/Crack</td>
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<td>Heroin</td>
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Any recent travel outside U.S.? O Y O N
14. Have you experienced any of the following in the last 6 months? (Please check all that apply)

**Constitutional**
- Fatigue/tire easily
- Weight loss: (______) lbs
- Trouble sleeping
- Poor appetite
- Frequent pain or distress
- Fevers
- Night sweats

**Respiratory**
- Asthma/wheezing
- Shortness of breath
- Coughing up blood
- Frequent infection

**Neurological**
- Frequent headaches
- Dizziness
- Numbness or tingling
- Weakness of arms/legs
- Memory loss

**Kidney/Bladder**
- Frequent urination
- Painful urination
- Blood in urine
- Incontinence/leakage of urine

**Musculoskeletal**
- Joint pains/arthritis
- Weakness
- Back pain
- Multiple broken bones

**Eyes**
- Blurring or double vision
- Pain or inflammation in eyes
- Other eye problems
- Blood in urine
- Incontinence/leakage of urine

**Blood/lymph**
- Anemia
- Large lymph nodes
- Easy bleeding or bruising
- Blood clots
- Blood transfusions

**Endocrine**
- Feeling too hot or cold

**Psychological**
- Stress at work
- Stress at home
- Feeling blue/depressed
- Feeling anxious/worried
- Not enjoying life
- Loss of interest in sex
- Unpleasant thoughts
- Depression

**Skin**
- Rash
- New growth on skin
- Ulcers, sores or red spots

**Cardiac**
- Chest pain
- Palpitations (rapid heart rate)
- Wake up at night short of breath

**Other**
- Sexual problems
- Heavy/abnormal menstrual bleeding

O Boxes left blank are negative