SANTA CLARA
VALLEY MEDICAL CENTER
Hospital & Clinics

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.

Your name:

Your primary care provider's name and address:

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.)

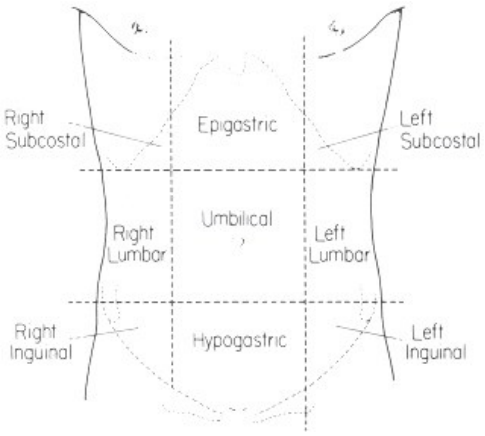
5. Preferred Pharmacy

□ Valley Specialty Center
□ Bascom
□ Downtown
□ East Valley
□ Gilroy
□ Lenzen
□ Milpitas
□ Moorpark
□ Sunnyvale
□ Tully

□ Other (specify name and location):_____

6. Do you have abdominal pain? O Yes O 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? O Burning O Stabbing O Cramping O Aching

O 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?	Better	Worse	No change
Eating	O	O	O
Bowel movement	O	O	O
Stress	O	O	O
Antacids	O	O	O
Other (specify) _____	O	O	O

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

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

8. Prior GI Evaluation

Have you seen a gastroenterologist (stomach, colon, or liver specialist) in the past? O Yes O No

If Yes, name and address of gastroenterologist: _____

Procedure	Date	Clinic or Hospital Location
Upper endoscopy (EGD) Colonoscopy Sigmoidoscopy Liver Biopsy Other (specify):		

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 Eosinophilic esophagitis
O Esophageal varices
O Fatty Liver
O Fibromyalgia
O Gallstones
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 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 Stroke
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

Date	Location	Problem

12. Family history: Please indicate if any of your family members have or had any medical problems

	Colon cancer	Colon polyps	Stomach cancer	Liver cancer	Pancreas cancer	GYN or GU cancer	Colitis/ IBD	Celiac disease	Liver disease	Age at diagnosis	Other medical problems (specify)	Currently alive?	Age at death
Father	O	O	O	O	O	O	O	O	O	_____	_____	O Y O N	_____
Mother	O	O	O	O	O	O	O	O	O	_____	_____	O Y O N	_____
Brother(s)	O	O	O	O	O	O	O	O	O	_____	_____	O Y O N	_____
Sister(s)	O	O	O	O	O	O	O	O	O	_____	_____	O Y O N	_____
Children	O	O	O	O	O	O	O	O	O	_____	_____	O Y O N	_____
Others (specify):	O	O	O	O	O	O	O	O	O	_____	_____	O Y O N	_____

13. Social History

Place of birth _____ Any recent travel outside U.S.? O Y O N

Substance use	Current	Former	Never	Date started	Date of most recent use	How often do you use?	How much do you use?	Ready to quit?
Wine	O	O	O					O Y O N
Beer	O	O	O					O Y O N
Hard Liquor	O	O	O					O Y O N
Cigarettes	O	O	O					O Y O N
E-Cigarettes	O	O	O					O Y O N
Other tobacco	O	O	O					O Y O N
Marijuana	O	O	O					O Y O N
Methamphetamines	O	O	O					O Y O N
Cocaine/Crack	O	O	O					O Y O N
PCP	O	O	O					O Y O N
Heroin	O	O	O					O Y O N
Ecstasy	O	O	O					O Y O N
LSD	O	O	O					O Y O N
Others (specify):	O	O	O					O Y O N
								O Y O N

14. Have you experienced any of the following in the last 6 months? (Please check all that apply)

Constitutional

o Fatigue/ tire easily

o Weight loss: (_____) lbs

o Trouble sleeping

o Poor appetite

o Frequent pain or distress

o Fevers

o Night sweats

Eyes

o Blurring or double vision

o Pain or inflammation in eyes

o Other eye problems

Ears/Nose/Throat

o Sour taste in mouth

o Stomach contents in mouth

o Sinus congestion or pain

o Earaches

o Frequent gum bleeds

o Sore throat

o Hoarse voice

o Severe tooth decay

Cardiac

o Chest pain

o Palpitations (rapid heart rate)

o Wake up at night short of breath

Respiratory

o Asthma/wheezing

o Shortness of breath

o Coughing up blood

o Frequent infection

Kidney/Bladder

o Frequent urination

o Painful urination

o Blood in urine

o Incontinence/ leakage of urine

Blood/lymph

o Anemia

o Large lymph nodes

o Easy bleeding or bruising

o Blood clots

o Blood transfusions

Endocrine

o Feeling too hot or cold

Skin

o Rash

o New growth on skin

o Ulcers, sores or red spots

Neurological

o Frequent headaches

o Dizziness

o Numbness or tingling

o Weakness of arms /legs

o Memory loss

Musculoskeletal

o Joint pains/ arthritis

o Weakness

o Back pain

o Multiple broken bones

Psychological

o Stress at work

o Stress at home

o Feeling blue/ depressed

o Feeling anxious/ worried

o Not enjoying life

o Loss of interest in sex

o Unpleasant thoughts

o Depression

Other

o Sexual problems

o Heavy/abnormal menstrual bleeding

O Boxes left blank are negative