# Gastrointestinal Surgical Specialists, LLC

## Patient History and Physical

**Signature**_____ **Date**_____

**Have you had or do you presently suffer from the following:**

| | YES | NO |
|---|---|---|
| Hepatitis | ____ | ____ |
| Pancreatitis | ____ | ____ |
| Jaundice | ____ | ____ |
| Ulcerative Colitis | ____ | ____ |
| Crohn's Disease | ____ | ____ |
| Irritable Bowel Syndrome | ____ | ____ |
| GERD | ____ | ____ |
| Stomach Ulcers | ____ | ____ |
| Constipation | ____ | ____ |
| Hemorrhoids | ____ | ____ |
| Anal Fissure | ____ | ____ |
| Anal Fistula | ____ | ____ |
| Rectal Abscess | ____ | ____ |
| Skin Conditions | ____ | ____ |
| Cataracts | ____ | ____ |
| Glaucoma | ____ | ____ |
| Asthma | ____ | ____ |
| Bronchitis | ____ | ____ |
| Pneumonia | ____ | ____ |
| Sleep Apnea | ____ | ____ |
| Emphysema | ____ | ____ |
| TB | ____ | ____ |
| Heart Attack | ____ | ____ |
| Angina | ____ | ____ |
| Congestive Heart Failure | ____ | ____ |
| Kidney Disease | ____ | ____ |
| Bladder CA | ____ | ____ |
| Prostate CA | ____ | ____ |
| Diabetes | ____ | ____ |
| Thyroid Disease | ____ | ____ |
| Broken Bones | ____ | ____ |
| Arthritis | ____ | ____ |
| Varicose Veins | ____ | ____ |
| Seizures | ____ | ____ |
| Depression | ____ | ____ |

**Please check if you have had any of the following:**

Colonoscopy _____ Date_____
Flex Sig _____ Date_____
Barium Enema_____ Date_____
Pap Smear _____ Date_____
Mammogram _____ Date_____
Cardiac Cath _____ Date_____
Stress Test _____ Date_____
Previous HIV Test___ Date _____
Aspirin use daily _____
Dentures____ Full Partial

Family history Colon Cancer?_____
Family history Rectal Cancer?_____

List past surgeries with date:

_____
_____
_____
_____
_____
_____
_____

Daily Medication List:

_____
_____
_____
_____
_____

Medicine Allergies:

_____
_____
_____
_____

Do you smoke cigarettes? _____
Packs per day _____Years_____
Do you drink alcohol? _____