Upstate Gastroenterology Associates. PC
2200 Burdett Ave, Suite 201/205
Troy, New York 12180

Patient History Form

Date: _____ Email: _____
Patient Name: _____ DOB: _____

Reason For Visit: _____

Demographic
Please circle one in each category:
Race: Asian African American Caucasian Hispanic Other_____
Language: English Spanish Other_____
Marital status: _____
Height: _____ Weight: _____

Health Maintenance:
Last Colonoscopy:_____
Last Pap smear: _____
Last mammogram: _____
Last Hepatitis A/B vaccinations: _____
Last Pneumococcal vaccination: _____

Do you smoke or use tobacco use? If so, how much: _____ Do you use alcohol? If so, how much: _____

Allergies (If yes, please list reaction):_____

Medications (all prescription/over the counter medications/supplements/herbs- including dose and frequency):
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8._____
*If needed, use reverse side for additional meds

Do you take any of the following? (If so, circle):

Aspirin/Ibuprofen Coumadin Eliquis Plavix Pradaxa Xarelto Other_____

From the list of surgeries/ medical problems, please circle any that you have or had:

Appendectomy Gallbladder removal Gastric bypass Bowel surgery Heart surgery/stent Colon cancer/polyps

Joint replacement Colitis Diverticulosis/diverticulitis Esophagitis GERD/heartburn Liver disease/hepatitis

Inflammatory bowel disease (Crohn's/ulcerative colitis) Stomach ulcer Pancreatitis Cancer (specify):_____

Arthritis Atrial fibrillation COPD Heart disease Diabetes ICD/pacemaker Sleep apnea Stroke

From the list of symptoms below, please circle any that you may have experienced:

Abdominal pain Bloating Diarrhea/constipation Blood in stool/black stool Change in bowel habits

Heartburn/Chest pain/Cough Jaundice Nausea/vomiting Pain/difficulty with swallowing Weight loss

Other: _____

Do you have a family history of any of the following? Celiac disease Colon cancer Crohn's /Ulcerative colitis Liver disease

Patient's Signature: _____ Date: _____

Provider's Signature: _____ Date: _____