

**MAIN LINE
GASTROENTEROLOGY ASSOCIATES, P.C.
NEW PATIENT HISTORY**

Name: _____

Date of Birth: _____

Do any of the following currently apply to you ? (Please circle all that apply)

- Yes / No Poor appetite / weight loss / weight gain / fevers / night sweats / chills / headaches / fatigue
- Yes / No Blurred vision / double vision / eye pain
- Yes / No Hearing impairment / sore throat / post nasal drip / nosebleeds / gum bleeding / ringing in the ears / dizziness
- Yes / No Palpitations / chest pain / irregular heart beat
- Yes / No Shortness of breath / wheezing / cough
- Yes / No Nausea or vomiting / abdominal pain / heartburn / constipation / change in bowels / difficulty swallowing / pain on swallowing / bloating / gaseousness / intolerance to dairy products / blood in bowel movements /

- Yes / No Burning on urination / blood in urine / frequent urination
- Yes / No Joint pain / arthritis / back pain / muscle aches
- Yes / No Skin rash / itching / jaundice / breast lump
- Yes / No Fainting spells / confusion / forgetfulness / weakness / difficulty controlling bowels or bladder
- Yes / No Excessive stress / depression / mood swings / anxiety / irritability / difficulty sleeping
- Yes / No Hot flashes / intolerance to hot or cold weather
- Yes / No Swollen glands / easy bruising
- Yes / No Seasonal allergies / hives / color changes or painful finger tips on exposure to cold
- Yes / No Victim of abuse

All others negative _____
(Dr Initials)

Please list all medications and dosages (including over-the-counter items, vitamins, and supplements):

- | | |
|----|-----|
| 1. | 8. |
| 2. | 9. |
| 3. | 10. |
| 4. | 11. |
| 5. | 12. |
| 6. | 13. |
| 7. | 14. |

Do you use Aspirin? Y N
 286.7 Coumadin? Y N
 Anti-inflammatory drugs (e.g. advil, motrin, ibuprofen, etc.)? Y N

Please list any drug allergies (e.g. Penicillin, Sulfa, etc.) or intolerances:

None

- | | |
|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

<input type="checkbox"/> Above reviewed with patient	
_____	_____
Date	Initials