History Form for Revisit

PITTSBURGH GASTROENTEROLOGY ASSOCIATES
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Secure Messaging Portal: https://pga.intakeq.com

1. Please enter the patient's information.

First (legal) Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: _____ Gender: ○ Female ○ Male

2. Primary Care Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

3. What medical problem or concern do you have?

_____

Please describe any updates regarding the above issue:

_____

_____

Any other questions or concerns you would like to discuss?

_____

_____

4. Please list updates on your health status since your last visit. Include newly diagnosed diseases, problems.

_____

_____

Please list updates on admissions, surgeries since your last visit. Include date, doctor, hospital and reason.

_____

_____

5. Have you had the following tests or any updates since your last visit? If yes, please list the last test: when, where, and ordered by whom? We will try to obtain the records.

- ○ Colonoscopy:
- ○ Upper Endoscopy (EGD):
- ○ Abdominal Ultrasound:
- ○ Abdominal CT scan:
- ○ Abdominal MRI:
- ○ Blood Work:

6. Please update all medications you are currently taking, including over-the-counter drugs, vitamins, herbs, aspirin, arthritis medications, etc. Describe Medication Name, Dose, Frequency, Ordered by, and Reason for Use.

_____

_____

_____

_____

7. Please update any allergies (including latex) and reaction.

_____

8. Please check your gastrointestinal symptoms:

☐ Abdominal Pain or Cramps	☐ Nausea	☐ Vomiting
☐ Vomiting Blood	☐ Heartburn / Acid Reflux	☐ Sour or Bitter Taste
☐ Regurgitation	☐ Belching	☐ Lumpy Feeling in Throat
☐ Difficult Swallowing	☐ Painful Swallowing	☐ Food Getting Stuck
☐ Choke or Cough after Swallowing	☐ Bloating	☐ Excessive Gas
☐ Indigestion	☐ Constipation	☐ Diarrhea
☐ Change in Bowel Habits	☐ Change in Size of Stool	☐ Blood in Stool
☐ Dark or Tarry Stool	☐ Mucus in Stool	☐ Foul Odor to Stool
☐ Stool Incontinence or Leaking	☐ Hemorrhoids	☐ Anal Itching
☐ Anal Burning	☐ Decrease in Appetite	☐ Food Intolerance/Sensitivity
☐ Jaundice/Yellow Skin or Eyes	☐ Unexplained Weight Gain	☐ Unexplained Weight Loss

9. List any other symptoms:

_____

10. Has any of your parents or siblings been diagnosed with colon cancer or GI disease since last visit?

○ Yes. ○ No. ○ If yes, please explain:

11. Do you smoke?

○ Yes ○ No ○ Past

12. Do you drink alcohol?

○ Yes. ○ No. ○ Past (quit date:_____). ○ If yes, list products and approximate weekly consumption:

13. Diet

Do you consume coffee, tea, caffeinated products regularly, including chocolate, cola?
○ Yes ○ No

Do you often consume artificial sweeteners?
○ Yes ○ No

Do you have any food intolerance or allergies to foods?
○ Yes. ○ No. ○ If yes, please explain:

14. Do you use recreational drugs or medical marijuana?

○ Yes. ○ No. ○ If yes, please explain:

15. Other Questions

When was last flu shot?	Last pneumonia shot?	Height	Weight	Occupation
_____	_____	_____	_____	_____

16. Are there any questions, concerns, or anything else you want us to know? Please describe.

_____