# THE UNIVERSITY OF KANSAS PHYSICIANS

## Department of Internal Medicine – Gastroenterology

Welcome to our practice. As a new patient, we will discuss your health in detail. To help us in these discussions, please fill out the information below to the best of your ability.

**Name**: _____
**KUMC #**: _____
**Date**: _____ **DOB**: _____

**Primary Care Doctor**: _____ **Phone:** (  ) _____ **Address**: _____

**Referring Doctor:** _____ **Phone**: (  ) _____ **Address**: _____

**Reason for Visit**: _____

_____

**MEDICAL HISTORY**

**Patient Medical History:**

| | | | **Recent and relevant hospitalizations/surgeries/serious injuries:** **When?** |
|---|---|---|---|
| Diabetes type I | Yes | No | |
| Diabetes type II | Yes | No | |
| Hypertension | Yes | No | |
| Cancer | Yes | No | |
| Stroke | Yes | No | |
| Heart trouble | Yes | No | **Medications, including prescription and over the counter. Dosage and frequency.** |
| Arthritis/gout | Yes | No | |
| Convulsions | Yes | No | |
| Bleeding tendency | Yes | No | |
| Acute infections | Yes | No | |
| Sexual disease | Yes | No | |
| Birth defects | Yes | No | |
| Thyroid problems | Yes | No | |
| Osteoporosis | Yes | No | **Allergies and reaction**: |
| Vision problems | Yes | No | |
| Hearing problems | Yes | No | |
| Ulcer/Stomach problems | Yes | No | |
| Back pain | Yes | No | |
| Other | | | |

**Patient Social History**:

| | | | | | |
|---|---|---|---|---|---|
| Marital Status | Single: _____ | Married: _____ | Separated: _____ | Divorced: _____ | Widowed: _____ |
| Use of alcohol | Never: _____ | Rarely: _____ | Moderate: _____ | Daily: _____ | Quit: _____ |
| Use of tobacco | Never: _____ | Previously, but quit: _____ | Current packs/day: _____ | | |
| Use of drugs | Never: _____ | Type/frequency: _____ | | | |
| Excessive exposure at home or work to: | Fumes: _____ | Dust: _____ | Solvents: _____ | Airborne Particles: _____ | Noise: _____ |

Occupation/work environment: _____

Do you have a living will or advanced directive? Yes No

**Family Medical History**:

| | Age | Diseases | If Deceased, Cause of Death |
|---|---|---|---|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Siblings | _____ | _____ | _____ |
| Spouse | _____ | _____ | _____ |
| Children | _____ | _____ | _____ |

Review of Systems. Please check the symptoms you are ***currently*** experiencing.

| CONSTITUTION | EYES | ENDOCRINE | ALLERGY/IMMUNOLOGY |
|---|---|---|---|
| ☐ Activity change | ☐ Eye discharge | ☐ Cold intolerance | ☐ Environmental allergies |
| ☐ Appetite change | ☐ Eye itching | ☐ Heat intolerance | ☐ Food allergies |
| ☐ Chills | ☐ Eye pain | ☐ Excessive thirst (Polydipsia) | ☐ Immunocompromised |
| ☐ Diaphoresis (Sweating) | ☐ Eye redness | ☐ Increased appetite (Polyphagia) | **NEUROLOGICAL** |
| ☐ Fatigue | ☐ Sensitivity to light (Photophobia) | ☐ Excessive urination volume (Polyuria) | ☐ Dizziness |
| ☐ Fever | ☐ Visual disturbances | **GENITOURINARY** | ☐ Facial asymmetry |
| ☐ Unexpected weight change | **RESPIRATORY** | ☐ Difficulty urinating | ☐ Headaches |
| **HEAD/ENT** | ☐ Apnea | ☐ Painful intercourse (Dyspareunia) | ☐ Light-headedness |
| ☐ Congestion | ☐ Chest tightness | ☐ Painful urination (Dysuria) | ☐ Numbness |
| ☐ Dental problem | ☐ Choking | ☐ Incontinence (Enuresis) | ☐ Seizures |
| ☐ Drooling | ☐ Cough | ☐ Flank pain | ☐ Speech difficulty |
| ☐ Ear discharge | ☐ Shortness of breath | ☐ Frequency | ☐ Fainting (Syncope) |
| ☐ Ear pain | ☐ Inhale wheeze (Stridor) | ☐ Genital sore | ☐ Tremors |
| ☐ Facial swelling | ☐ Wheezing | ☐ Blood in urine (Hematuria) | ☐ Weakness |
| ☐ Hearing loss | **CARDIOVASCULAR** | ☐ Menstrual problem | **HEMATOLOGIC** |
| ☐ Mouth sores | ☐ Chest pain | ☐ Pelvic pain | ☐ Enlarged lymph node (Adenopathy) |
| ☐ Nosebleeds | ☐ Leg swelling | ☐ Urgency | ☐ Bruises/bleeds easily |
| ☐ Postnasal drip | ☐ Palpitations | ☐ Urine decreased | **PSYCHIATRIC** |
| ☐ Rhinorrhea (Runny Nose) | **GASTROINTESTINAL** | ☐ Vaginal bleed | ☐ Agitation |
| ☐ Sinus pressure | ☐ Abdominal distension | ☐ Vaginal discharge | ☐ Behavior problem |
| ☐ Sneezing | ☐ Abdominal pain | ☐ Vaginal pain | ☐ Confusion |
| ☐ Sore throat | ☐ Anal bleeding | **MUSCULOSKELETAL** | ☐ Decreased concentration |
| ☐ Tinnitus (Ringing in ear) | ☐ Blood in stool | ☐ Joint pain (Arthralgias) | ☐ Dysphoric mood |
| ☐ Trouble swallowing | ☐ Constipation | ☐ Back pain | ☐ Hallucinations |
| ☐ Voice change | ☐ Diarrhea | ☐ Gait problem | ☐ Hyperactive |
| | ☐ Nausea | ☐ Joint swelling | ☐ Nervous/anxious |
| | ☐ Rectal pain | ☐ Muscle pain (Myalgias) | ☐ Self-injury |
| | ☐ Vomiting | ☐ Neck pain | ☐ Sleep disturbance |
| | | ☐ Neck stiffness | ☐ Suicidal thoughts |
| | | **SKIN** | |
| | | ☐ Color change | |
| | | ☐ Pale skin | |
| | | ☐ Rash | |
| | | ☐ Wound | |