CIRCLE CITY
GASTROENTEROLOGY

2250 South Main Street, Suite 201, Corona, CA 92882 • (951) 808-6298 • CircleCityGi.com

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____ Email (Personal): _____

Preferred Language: _____ English _____Spanish _____ Patient Declines

Contact Preference: _____ Letter _____ Email _____ Other _____ Patient Declines

Pharmacy Information

Name: _____ Telephone: _____

Pharmacy Complete Address: _____

Allergies (check all that apply)

_____ Patient has no known allergies _____Patient has no known drug allergies

_____ Adhesive Tape _____ Codeine Sulfate _____ Erythromycin _____ Penicillin's

_____ Shellfish _____ IV Dye, Iodine Containing Contrast Media _____ Latex Gloves

Diagnostic Studies/Tests (check all that apply and provide date completed)

_____ None _____ Colonoscopy: _____ Date _____ EGD: _____ Date

_____ CT Abdomen/Pelvis: _____ Date _____ MRI Abdomen/Pelvis: _____ Date

_____ ERCP: _____ Date Pathology: _____ Date

Previous Procedures (check all that apply)

_____ None _____ Gallbladder Removed _____ Appendectomy _____ Colon Resection

_____ Small Bowel Resection _____ Exploratory Laparoscopy _____ Gastric Bypass

_____ Gastric Lap Band _____ Hemorrhoidectomy _____ Hemorrhoid Banding

_____ Abdominoplasty _____ Bilateral Tubal Ligation (BTL) _____ Mastectomy

_____ Pacemaker Insertion _____ Defibrillator Placement

_____ Coronary Artery Bypass Graft (CABG) _____ Heart Valve Replacement

_____ Abdominal Aortic Aneurysm (AAA) Repair _____ Cardiac Cath-with Stent Placement

_____ Joint Replacement _____ Back Surgery _____ Fibromyalgia

_____ Other: _____ _____Other: _____

Past or Present Medical Conditions (check all that apply)

Gastroenterology/Hepatology

_____ Colon Polyp History _____ Colon Cancer _____ Irritable Bowel Syndrome

_____ Diverticulitis ___Crohn's Disease _____Ulcerative Colitis _____ Barrett's Esophagus

_____ Gastroesophageal Reflux Disease (GERD) _____ Ulcer Disease _____ Hepatitis B

_____ Hepatitis C _____ Fatty Liver _____ Cirrhosis _____ Celiac Disease

_____ Pancreatitis _____ Bowel Obstruction _____ Anemia _____ Other: _____

Cardiology

_____ Coronary Artery Disease _____ Congestive Heart Failure _____ Heart Attack

_____ High Blood Pressure _____ Atrial Fibrillation _____ Vascular Disease

_____ High Cholesterol _____ Stroke _____ Transient Ischemic Attack _____ Pacemaker

_____ Valvular Heart Disease _____ Coronary Artery Stents _____ Other: _____

Pulmonology

_____ C.O.P.D. _____ Asthma _____ Sleep Apnea _____ Blood Clots (leg)

_____ Blood Clots (lung) _____ Wheezing _____ Other: _____

Other

_____ Anxiety Disorder _____ Arthritis _____ Bipolar Disorder _____ Body Piercings

_____ Breast Cancer _____ Current Pregnancy _____ Depression _____ Gout

_____ Diabetes Mellitus, Insulin Dependent (Type 1) _____ Fibrositis/Fibromyalgia

_____ Diabetes Mellitus, Insulin Dependent (Type 2) _____HIV Exposure _____ Seizures

_____ HIV Infection _____ Hypothyroidism _____ Kidney Disease _____ Kidney Stones

_____ Lung Cancer _____ Ovarian Cancer _____ Prostate Cancer _____ Skin Cancer

_____ Tattoos

Social History

Occupation: _____ Number of Children: _____

Marital Status

_____ Single _____ Married _____ Divorced _____ Separated _____ Widowed

_____ Civil Union _____ Unknown _____ Other: _____

Alcohol

_____ None _____ Occasionally _____ Daily

Caffeine

_____ None _____ Occasionally _____ Daily

Tobacco

Smoking Status

_____ Current Every Day Smoker _____ Current Some Day Smoker _____ Former Smoker

_____ Never Smoker _____ Smoker, Current Status Unknown _____ Light Tobacco Smoker

_____ Heavy Tobacco Smoker _____ Unknown if Ever Smoked

Type

_____ Cigarettes _____
Started Quit Quantity Frequency

_____ Cigar _____
Started Quit Quantity Frequency

_____ Chewing Tobacco _____
Started Quit Quantity Frequency

Drug Use

_____ None _____ IV or Intranasal Drugs _____
Quantity Number Frequency

Recreational _____
Quantity Number Frequency

Exercise

_____ None _____ Regular Exercise _____ Occasional Exercise

Family Medical History

_____ No Knowledge of Family History

No Family History Of: _____ Colon Cancer _____ Colon Polyps _____ Liver Disease

_____ Stomach Cancer

Diagnosis	Mother	Father	Sister	Brother	Son	Daughter
Celiac Disease						
Colon Cancer						
Colon Polyps						
Crohn's Disease						
Gallbladder Disease						
Liver Disease						
Ulcerative Colitis						

Review of Systems

Cardiovascular

⬭ None ⬭ Chest Pain ⬭ Palpitations

Hematologic/Lymphatic

⬭ None ⬭ Easy Bruising ⬭ Palpable Masses ⬭ Lymphadenopathy

Respiratory

⬭ None ⬭ Cough ⬭ Difficulty Breathing

Constitutional

⬭ None ⬭ Fever ⬭ Chills ⬭ Significant Weight Changes

Integumentary

⬭ None ⬭ Jaundice ⬭ Rashes

ENMT

⬭ None ⬭ Difficulty Swallowing ⬭ Ear Pain ⬭ Hearing Changes

⬭ Ear Discharge

Musculoskeletal

⬭ None ⬭ Joint Pain ⬭ Difficulty Walking

Eyes

⬭ None ⬭ Scleral Icterus ⬭ Eye Pain ⬭ Vision Changes

Neurological

⬭ None ⬭ Frequent Headaches ⬭ Weakness

Gastrointestinal

⬭ None ⬭ Abdominal Pain ⬭ Change in Bowel Habits ⬭ Constipation

⬭ Diarrhea ⬭ Nausea ⬭ Rectal Bleeding ⬭ Vomiting

Psychiatric

⬭ None ⬭ Anxiety ⬭ Depression ⬭ Changes in Mood

Consent to Import Medical History

I consent to obtaining a history of my medications purchased at pharmacies.

⬭ Yes ⬭ No

Reminder Preference

I would like to receive preventative care and follow-up care reminders.

⬭ Yes ⬭ No

Reviewed With

⬭ Patient ⬭ Parent ⬭ Guardian ⬭ Not Present

Printed Name: _____ Date: _____

Signature: _____