

# Southwest Digestive Specialists

---

**Bradford C. Gelzayd, MD, FACP, FACG**

**Patient History and Physical**

---

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

**Review of Systems:**

**(fill out before office visit)**

|   | <u>Yes</u> | <u>No</u> |
|---|------------|-----------|
| Nausea  | _____      | _____     |
| Vomiting (with blood- yes or no; circle one)  | _____      | _____     |
| Fever; how high (F') _____  | _____      | _____     |
| Weight loss; How much (lbs) _____   | _____      | _____     |
| Diarrhea; How many times per day _____  | _____      | _____     |
| Constipation; BM's per week _____   | _____      | _____     |
| Alternate between constipation and diarrhea   | _____      | _____     |
| Bloating/Gas/Abdominal distension-(circle each)   | _____      | _____     |
| Abdominal Pain (middle, left upper, left lower, right upper,<br>right lower, below breast bone, all over)-(circle each) | _____      | _____     |
| Rectal bleeding   | _____      | _____     |
| Black, tarry stool  | _____      | _____     |
| Heartburn/regurgitation/sour taste- (circle each)   | _____      | _____     |
| Burning on swallowing citrus juice  | _____      | _____     |
| Chest pain  | _____      | _____     |
| Food sticking on or after swallowing  | _____      | _____     |
| Jaundice  | _____      | _____     |
| Itching   | _____      | _____     |
| Persistent darkened urine   | _____      | _____     |
| Rash/oral ulcers/lower back pain/multiple joint pain-(circle each)  | _____      | _____     |

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

**Past Medical History**

What medical diagnoses do you have  
or take medicine for:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

Other: \_\_\_\_\_

**Past surgical History**

What surgeries have you undergone:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

Other: \_\_\_\_\_

**Social Habits (circle all that apply):**

Married/single/widow/divorced (circle one)

Occupation \_\_\_\_\_ Retired? \_\_\_\_\_

Smoker- yes or no; if yes, what and how many packs per day \_\_\_\_\_

Children-yes or no; how many \_\_\_\_\_

Intravenous drugs/other illicit drugs; if yes, then what years \_\_\_\_\_

Blood transfusion before 1992- yes or no; if yes, what year(s) \_\_\_\_\_

Tattoos- yes or no; if yes, then how many and what years place \_\_\_\_\_

**Family History of Medical Problems:**

Colon cancer/colon polyps-What relative and their  
age \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

**Family History of Medical Problems (cont.):**

Other GI Malignancy (Esophagus, Stomach, Pancreas, Liver, or intestines)- what relative and their age \_\_\_\_\_

Liver Disease; if yes, then what relative and what problem \_\_\_\_\_

Crohn's Disease or Ulcerative Colitis (circle each)- if yes, then what relative \_\_\_\_\_

**Other:**

Mom \_\_\_\_\_

Dad \_\_\_\_\_

Siblings \_\_\_\_\_

Grandparents (maternal or paternal) \_\_\_\_\_

---

**Last Colonoscopy-** date(s) \_\_\_\_\_ Polyps /Diverticulosis/ Hemorrhoids  
(Circle each)

**Last Upper endoscopy-**date(s) \_\_\_\_\_

What was found \_\_\_\_\_

**Drug Allergies (Causes a rash, swelling in throat, difficulty breathing or passing out):**

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

**Current Medications (names and dosages):**

- |    |     |
|----|-----|
| 1. | 6.  |
| 2. | 7.  |
| 3. | 8.  |
| 4. | 9.  |
| 5. | 10. |

**Woman only:** Pregnant? Yes\_\_\_\_\_ No\_\_\_\_\_

Planning Pregnancy? Yes\_\_\_\_ No\_\_\_\_