



# Gastroenterology Clinic of San Antonio, P.A.

David L. Stump, M.D., FACP, FACG  
Charles W. Randall, M.D.  
V. Franz Zurita, M.D.  
Russell Dean Havranek, M.D.  
Christopher A. Fincke, M.D.

Patient Medical  
Information Sheet

**Gastroenterology Clinic of San Antonio, P.A.**

8550 Data Point #LL100  
San Antonio, Texas 78229

Updated: 10/06

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
 Primary Dr.: \_\_\_\_\_ Referring Dr. / Person: \_\_\_\_\_  
 Reason For Today's Visit \_\_\_\_\_

Medications Currently Taking (including birth control pills, vitamins, aspirin, ibuprofen, herbal supplements, etc.)

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

Drug Allergies and Reactions

1. _____	3. _____	5. _____
2. _____	4. _____	6. _____

Medical Diseases/Problems/Hospitalizations (for example: diabetes, high blood pressure, depression, glaucoma)

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

Operations and Date (for example open heart surgery, gallbladder, hysterectomy, etc.)

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

**FAMILY HISTORY:** does your brother, sister, parents or children have any of the following? (please check)

- |  |   |                                    |                                  |
|--|---|------------------------------------|----------------------------------|
| <input type="checkbox"/> Celiac Sprue                            | <input type="checkbox"/> Gallbladder Stones       | Cancer of:                         | <input type="checkbox"/> Colon   |
| <input type="checkbox"/> Cirrhosis of Liver                      | <input type="checkbox"/> Hemochromatosis          | <input type="checkbox"/> Esophagus | <input type="checkbox"/> Breast  |
| <input type="checkbox"/> Colitis (Crohn's or Ulcerative Colitis) | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Liver     | <input type="checkbox"/> Cervix  |
| <input type="checkbox"/> Colon Polyps                            | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Pancreas  | <input type="checkbox"/> Ovaries |
| <input type="checkbox"/> Diverticulosis/-itis                    | <input type="checkbox"/> Stomach Ulcers           | <input type="checkbox"/> Stomach   | <input type="checkbox"/> Uterus  |

**SOCIAL HISTORY AND HABITS:** please check and give average amounts

Smoke / Chew Tobacco     Yes     No    How many years? \_\_\_\_\_    How many packs per day? \_\_\_\_\_  
 Drink Coffee     Yes     No    Number of cups / glasses per day? \_\_\_\_\_  
 Drink Beer, Wine or Hard Liquor     Yes     No    Number of drinks \_\_\_\_\_ per  Day     Week     Month  
 Place of Birth: \_\_\_\_\_    Level of Education: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Matital Status:     Single     Married     Divorced     Widowed    Significant Other's Occupation: \_\_\_\_\_  
 Children and Ages: \_\_\_\_\_

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**REVIEW OF SYSTEMS:** please check any of the following Symptoms or conditions you have had in the last 3 months

**GI**

- abdominal bloating distension or gas
- abdominal pain, burning or discomfort
- black tarry stools
- bright red blood in stools
- constipation
- diarrhea
- difficulty swallowing
- fatigue
- fill up more easily at meals
- heartburn or indigestion
- hemorrhoids
- jaundice
- nausea
- vomited blood or "coffee grounds"
- vomiting

**EYES**

- eye pain or redness
- trouble with vision

**CONSTITUTIONAL**

- decrease in appetite
- fever or chills
- weight change in past 6 months

**ENT**

- hoarse voice
- lump in throat
- recurrent mouth ulcers
- sinus draining
- sore throat

**GENITOURINARY**

- frequent urination at night
- pain with urination
- pain with intercourse

last menstrual period \_\_\_\_\_

# of pregnancies \_\_\_\_\_

# of live births \_\_\_\_\_

**HEMATOLOGIC/LYMPH**

- bleed or bruise easily

**CARDIOVASCULAR:**

- heart palpitations or pounding
- heart problems
- shortness of breath with exercise
- shortness of breath with mild activity
- sleep on more than 1 pillow
- swelling of feet

**MUSCULOSKELETAL**

- arthritis
- muscle pain

**NEUROLOGICAL:**

- dizzy spells
- seizures or black outs
- HA's

**PULMONARY:**

- frequent cough
- phlegm production
- wheezing or asthma

**PSYCHIATRIC:**

- anxiety or depression

**PREVIOUS EVALUATION**

**LABORATORY:**

**X-RAY:**

**ENDOSCOPY:**

Nurse / MA Signature \_\_\_\_\_

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_