DAKOTA
Gastroenterology Clinic

Patient Name: _____
Patient DOB: _____
Date of Service: _____

Social History:
Marital Status: □ Single □ Married □ Divorced □ Widowed
Profession: _____
Smoke or Chew Tobacco: □ Never Used □ Quit Year: _____ □ Current User: _____
Alcohol use: □ none □ 1-2 drinks / week □ 1-2 drinks / day □ >2 drinks / Day □ Binge: _____
Drug Use: _____

Review of Systems: Please check all that apply to you
□ All Negative

General: □ Negative
□ Weight loss or Gain
□ Fevers or Chills

Cardiovascular / Heart: □ Negative
□ Palpitations
□ Chest pain

Respiratory / lung: □ Negative
□ Cough
□ Shortness of Breath

Urology / Kidney: □ Negative
□ burning when you pee
□ Increase Frequency

Neurology: □ Negative
□ Headaches
□ Numbness

Joint: □ Negative
□ Pain
□ Swelling

Psych: □ Negative
□ Depression
□ Anxiety

Skin: □ Negative
□ Rash
□ Itching

Hematology / lymph: □ Negative
□ Easy Bruising
□ Lymph nodes swelling

NOTES:

Vitals:
BP: _____ P: _____ Ht: _____ Wt: _____

Clinician Signature: _____ Date: _____ Time: _____

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Patient Name: _____
Patient DOB: _____
Date of Service: _____

PCP: _____

This form is being completed by: □ Patient □ Family □ other: _____

Reason for Visit:

_____

Allergies: □ None □ other:

_____

_____

Medications: (May attach list or fill in the table below)

Medication	Dose	Reason

Comments:

_____

_____

Past Medical History:

_____

_____

_____

Past Surgical History:

_____

_____

_____

Past Colonoscopy: _____
Past Upper Endoscopy: _____

Family History:
Colon Cancer: □ No □ Yes: _____
Colon Polyps: □ No □ Yes: _____
Crohn's disease: □ No □ Yes: _____
Ulcerative Colitis: □ No □ Yes: _____
Celiac Disease: □ No □ Yes: _____
Liver Disease: □ No □ Yes: _____
Other: _____

Clinician Signature: _____ Date: _____ Time: _____