





# Jordan & Associates

GASTROENTEROLOGY, P.A.

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415-C N. 7<sup>th</sup> Street, Smithfield, NC 27577

Phone : 919-938-4404 Fax: 919-938-3055

<input type="checkbox"/>	LEAKY HEART VALVE	<input type="checkbox"/>	ANGINA	<input type="checkbox"/>	HEART MURMUR
<input type="checkbox"/>	IRREGULAR HEARTBEAT	<input type="checkbox"/>	PACEMAKER	<input type="checkbox"/>	ASTHMA
<input type="checkbox"/>	RHEUMATIC FEVER	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	MULTIPLE SCLEROSIS
<input type="checkbox"/>	EMPHYSEMA	<input type="checkbox"/>	PNEUMONIA	<input type="checkbox"/>	CROHN'S DISEASE
<input type="checkbox"/>	ULCERATIVE COLITIS	<input type="checkbox"/>	STOMACH ULCER	<input type="checkbox"/>	HIATAL HERNIA
<input type="checkbox"/>	CELIAC DISEASE	<input type="checkbox"/>	PANCREATITIS	<input type="checkbox"/>	BARRETT'S ESOPHAGUS
<input type="checkbox"/>	COLON POLYPS	<input type="checkbox"/>	COLON CANCER	<input type="checkbox"/>	KIDNEY DISEASE
<input type="checkbox"/>	DIALYSIS	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	FIBROMYALGIA
<input type="checkbox"/>	MIGRAINES	<input type="checkbox"/>	SEIZURES	<input type="checkbox"/>	ANEMIA
<input type="checkbox"/>	OTHER:				

**Comments:** (Type of cancer and any other important related information:

Have you ever had problems with anesthesia?  YES  NO (DESCRIBE): \_\_\_\_\_

### Surgical History [Please check (√) if you have had the following]

<input type="checkbox"/>	GALLBLADDER SURGERY	<input type="checkbox"/>	APPENDECTOMY	<input type="checkbox"/>	TUBAL LIGATION
<input type="checkbox"/>	HYSTERECTOMY	<input type="checkbox"/>	D&C	<input type="checkbox"/>	CESAEREAN SECTION
<input type="checkbox"/>	CATARACT (R OR L)	<input type="checkbox"/>	LAPAROSCOPY	<input type="checkbox"/>	HEART VALVE REPLACEMENT
<input type="checkbox"/>	NISSEN FUNDOPLICATION	<input type="checkbox"/>	COLONOSCOPY	<input type="checkbox"/>	UPPER ENDOSCOPY
<input type="checkbox"/>	PROSTATE SURGERY	<input type="checkbox"/>	KNEE REPLACEMENT (R OR L)	<input type="checkbox"/>	ROTATOR CUFF REPAIR (R OR L)
<input type="checkbox"/>	THYROIDECTOMY	<input type="checkbox"/>	PILONIDAL CYST	<input type="checkbox"/>	TONSILLECTOMY
<input type="checkbox"/>	COLORECTAL SURGERY				
<input type="checkbox"/>	OTHER:				

### FAMILY HISTORY: [PLEASE (√) IF APPLICABLE]

<input checked="" type="checkbox"/>	MEDICAL CONDITION	FAMILY MEMBER	<input checked="" type="checkbox"/>	MEDICAL CONDITION	FAMILY MEMBER
<input type="checkbox"/>	COLON CANCER AGE ____		<input type="checkbox"/>	HIGH BLOOD PRESSURE	
<input type="checkbox"/>	COLON POLYPS		<input type="checkbox"/>	CONGESTIVE HEART FAILURE	
<input type="checkbox"/>	CROHN'S DISEASE		<input type="checkbox"/>	HEART ATTACK	
<input type="checkbox"/>	ULCERATIVE COLITIS		<input type="checkbox"/>	CIRRHOSIS	
<input type="checkbox"/>	STROKE		<input type="checkbox"/>	HEART DISEASE	
<input type="checkbox"/>	HEPATITIS		<input type="checkbox"/>	EMPHYSEMA	
<input type="checkbox"/>	ASTHMA		<input type="checkbox"/>	OVARIAN CANCER	
<input type="checkbox"/>	GARDNER'S SYNDROME		<input type="checkbox"/>	BREAST CANCER	
<input type="checkbox"/>	DIABETES		<input type="checkbox"/>	LUNG CANCER	
<input type="checkbox"/>	UTERINE CANCER		<input type="checkbox"/>	LIVER CANCER	
<input type="checkbox"/>	PROSTATE CANCER		<input type="checkbox"/>	PANCREATIC CANCER	
<input type="checkbox"/>	OTHER:				



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### Social History [PLEASE CHECK(✓) IF APPLICABLE AND GIVE USAGE

[✓] PRODUCT AMOUNT USED	[✓] PRODUCT AMOUNT USED	[✓] PRODUCT AMOUNT USED
<input type="checkbox"/> CIGARETTES _____	<input type="checkbox"/> DAILY BEER: _____	<input type="checkbox"/> CHEWING TOBACCO _____
<input type="checkbox"/> DAILY WINE _____	<input type="checkbox"/> SNUFF _____	<input type="checkbox"/> DAILY WHISKEY _____
<input type="checkbox"/> CIGARS _____	<input type="checkbox"/>	<input type="checkbox"/>

DAILY ILLEGAL DRUGS: TYPE: \_\_\_\_\_ FREQUENCY: \_\_\_\_\_

### PLEASE CHECK (✓) IF YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING:

[✓]	[✓]	[✓]
<input type="checkbox"/> LOSS OF APPETITE	<input type="checkbox"/> FEVER	<input type="checkbox"/> SKIN RASH
<input type="checkbox"/> NECK PAIN	<input type="checkbox"/> STIFF NECK	<input type="checkbox"/> CHANGE IN SKIN COLOR
<input type="checkbox"/> SWOLLEN GLANDS	<input type="checkbox"/> VISION PROBLEMS	<input type="checkbox"/> DEAFNESS
<input type="checkbox"/> HOARSENESS	<input type="checkbox"/> ABDOMINAL PAIN	<input type="checkbox"/> DIARRHEA
<input type="checkbox"/> BLACK TARRY STOOLS	<input type="checkbox"/> RECTAL BLEEDING	<input type="checkbox"/> CONSTIPATION
<input type="checkbox"/> NAUSEA	<input type="checkbox"/> VOMITING	<input type="checkbox"/> BLOOD IN YOUR STOOL
<input type="checkbox"/> ABDOMINAL CRAMPS	<input type="checkbox"/> DIFFICULTY SLEEPING	<input type="checkbox"/> ABDOMINAL DISTENTION
<input type="checkbox"/> ABDOMINAL BLOATING	<input type="checkbox"/> PAINFUL BOWEL MOVEMENTS	<input type="checkbox"/> DIFFICULT SWALLOWING
<input type="checkbox"/> WEIGHT LOSS	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> SEIZURES
<input type="checkbox"/> FAINTNG SPELLS	<input type="checkbox"/> LOSS OF CONSCIOUSNESS	<input type="checkbox"/> ANEMIA
<input type="checkbox"/> PROLONGED BLEEDING	<input type="checkbox"/> EASY BRUISING	<input type="checkbox"/> JOINT PAIN
<input type="checkbox"/> JOINT STIFFNESS	<input type="checkbox"/> JOINT REDNESS	<input type="checkbox"/> HIGH BLOOD PRESSURE
<input type="checkbox"/> SWELLING	<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> DIFFICULTY BREATHING
<input type="checkbox"/> DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>

### PLEASE CHECK [✓] THE TERMS THAT BEST DESCRIBE YOUR BOWEL MOVEMENTS:

[✓]	[✓]	[✓]	[✓]
<input type="checkbox"/> NORMAL CONSISTENCY	<input type="checkbox"/> BLACK& TARRY	<input type="checkbox"/> BLACK	<input type="checkbox"/> SOFT
<input type="checkbox"/> MIXED WITH BLOOD & MUCUS	<input type="checkbox"/> LIQUID/PASTY	<input type="checkbox"/> SEEDY	<input type="checkbox"/> GREEN
<input type="checkbox"/> FOUL SMELLING	<input type="checkbox"/> HARD/FIRM	<input type="checkbox"/> PELLET	<input type="checkbox"/> YELLOW
<input type="checkbox"/> FLOATS ON WATER	<input type="checkbox"/> WATERY	<input type="checkbox"/> BROWN	<input type="checkbox"/> BLOODY

How many bowel movements do you have a day? \_\_\_\_\_



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### PREVIOUS EVALUATIONS AND GIVE DATE (PLEASE CHECK [✓] PREVIOUS EVALUATIONS

[✓]	<input type="checkbox"/> BARIUM ENEMA (YEAR) _____	[✓]	<input type="checkbox"/> FLEX SIGMOIDOSCOPY (YEAR) _____	[✓]	<input type="checkbox"/> UPPER ENDO (YEAR) _____
	<input type="checkbox"/> PROCTOSCOPY (YEAR) _____		<input type="checkbox"/> COLONOSCOPY (YEAR) _____		<input type="checkbox"/> CAPSULE ENDO(YEAR)_____

Have you ever been told you needed an antibiotic prior to an invasive procedure? \_\_\_\_\_YES \_\_\_\_\_NO

If so please explain. \_\_\_\_\_

Who will be driving you home after your procedure? \_\_\_\_\_

Please leave all jewelry and valuables at home the day of your procedure.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_