Bucks County
Gastroenterology
Associates, P.C.

DATE________________PATIENT NAME_____________________________________

BIRTHDATE___________________ ILLNESS/SURGERIES:

OCCUPATION_________________ ____

MARITAL STATUS: ____

M___S___D___ W___ ____

CHIEF COMPLAINT:___________ ____

______________________________ ____

______________________________ ____

FAMILY HISTORY/RELATION:

CANCER____________________ POLYPS______________________________

ULCER_______________________ LIVER DISEASE________________________

PANCREATITIS______________ GALLBLADDER DISEASE_____________

NOTE ANY ILLNESSES – IF DECEASED, GIVE AGE AND CAUSE OF DEATH:

FATHER____________________________MOTHER______________________________

BROTHERS/SISTERS_________________ SPOUSE______________________________

CHILDREN____

MEDICINES—LIST ALL PRESCRIPTION, OVER-THE-COUNTER DRUGS, VITAMINS, ETC.____

____

____

DO YOU SMOKE______#PACKAGES PER DAY____#YEARS SMOKED___________

DO YOU USE ALCOHOL______________________#DRINKS PER WEEK__________

ALLERGIES TO DRUGS:____

OTHER ALLERGIES:____

PLEASE CONTINUE TO BACK OF PAGE IF NEEDED

REVIEWED BY______________________