# Digestive and Liver Care Center of Florida

*17222 Hospital Blvd, Suite 302 Brooksville, Fl 34601*

*12900 Cortez Blvd suite 203, Brooksville, FL 34613*

*352-765-3001*

*352-597-7744*

Today's Date:_____
Name:_____
___

**Constitutional:**
___Yes___No Recent Weight Change
___Yes___No Fever
___Yes___No Fatigue

**Eyes:**
___Yes___No Blurred Vision
___Yes___No Glaucoma

**Ears/ Nose/ Throat:**
___Yes___No Hearing Loss
___Yes___No Ringing in Ears
___Yes___No Mouth Sores

**Cardiovascular:**
___Yes___No Chest Pain
___Yes___No Pacemaker____Defibrillator
___Yes___No Mitral Valve Disease
___Yes___No Shortness of Breath
___Yes___No Swelling of Ankles
___Yes___No Do you take blood thinners?
___Yes___No Do you take Aspirin or Advil?

**Respiratory:**
___Yes___No Chronic Cough
___Yes___No Spitting Up Blood
___Yes___No Wheezing

**Genitourinary:**
___Yes___No Burning with Urination
___Yes___No Blood In Urine

**Musculoskeletal:**
___Yes___No Joint Pain/ Swelling
___Yes___No Back Pain
___Yes___No Muscle Pain
___Yes___No Joint Replacement (knee or hip)

**Skin:**
___Yes___No Rash
___Yes___No Itching

**Hematological:**
___Yes___No Bleeding Tendency
___Yes___No Bruising Tendency
___Yes___No Anemia
___Yes___No Past Transfusion

___Yes___No Are you pregnant?

**Have you ever had:**
___Yes___No Cancer
___Yes___No Colon Polyps
___Yes___No Gastric Polyps
___Yes___No Ulcers
___Yes___No Liver Disease
___Yes___No Pancreatitis
___Yes___No Kidney Disease

**Endrocrine:**
___Yes___No Heat/ Cold Intolerance
___Yes___No Excessive Thirst/ Urination
___Yes___No Diabetic

**Psychiatric:**
___Yes___No Memory Loss/ Confusion
___Yes___No Depression

**Neurological:**
___Yes___No Headaches
___Yes___No Seizures
___Yes___No Strokes
___Yes___No Numbness

**Gastrointestinal:**
___Yes___No Poor Appetite
___Yes___No Difficulty Swallowing
___Yes___No Heartburn
___Yes___No Nausea/ Vomiting
___Yes___No Constipation
___Yes___No Diarrhea
___Yes___No Abdominal Pain
___Yes___No Rectal Bleed
___Yes___No Black Tarry Stools

**Previous Procedures:**
___Yes___No Colonoscopy
___Yes___No EGD
If "Yes"
when:_____Doctor:_____

**Social Habits:**
___Yes___No Have you ever smoked?
___Yes___No Do you currently smoke?
_____ If YES, packs per day?
___Yes___No Have you ever drank alcohol?
___Yes___No Do you currently drink?
_____ If YES, how much?

**Family History:**
Has your mother, father, sister, or brother ever had?
(M=mother)(F=father)(S=sister)(B=brother)
___M___F___S___B Cancer
___M___F___S___B Colon Polyps
___M___F___S___B Gastric Polyps
___M___F___S___B Ulcers
___M___F___S___B Liver Disease
___M___F___S___B Pancreatitis
___M___F___S___B High Blood Pressure
___M___F___S___B Allergies
___M___F___S___B Psychiatric Problems
___M___F___S___B Diabetes
___M___F___S___B Other Diseases:
Please Explain:
_____
_____
_____

| Please Explain: | |
| --- | --- |
| | |