North Texas Gastrointestinal Associates, P.A.

2501 Scripture Street, Suite 201 • Denton, Texas 76201 • Ph: (940) 566-4720 • Fax: (940) 566-4727 • www.ntgi.com

Shawn William Panzer, M.D.

Name ______________________________ Age __________ Date __________

REASON FOR THIS VISIT IS ______________________________

Referring M.D. ______________________ Other M.D./OB GYN ______________________

PLEASE LIST ANY DRUG OR FOOD ALLERGIES: ______________________________

DO YOU CURRENTLY HAVE ANY OF THESE PROBLEMS: (FILL OUT FRONT & BACK)

CONSTITUTIONAL SYMPTOMS

Yes	No	
☐	☐	Recent weight loss/gain
☐	☐	Fever/chills
☐	☐	Fatigue

HEMATOLOGIC/LYMPHATIC

Yes	No	
☐	☐	Bleeding or bruising
☐	☐	Anemia

GASTROINTESTINAL

Yes	No	
☐	☐	Trouble swallowing
☐	☐	Painful swallowing
☐	☐	Gallbladder problems
☐	☐	Yellow skin color/jaundice
☐	☐	Abdominal pain
☐	☐	Constipation
☐	☐	Laxative use
☐	☐	Poor appetite
☐	☐	Hepatitis
☐	☐	Hemorrhoids
☐	☐	Pain with bowel movements
☐	☐	Food/milk intolerance
☐	☐	Hernia
☐	☐	Vomiting blood
☐	☐	Diarrhea
☐	☐	Blood in bowel movement
☐	☐	Acid reflux/Heartburn
☐	☐	Indigestion
☐	☐	Nausea/vomiting/regurg.
☐	☐	Other __________

EYES

Yes	No	
☐	☐	Eye disease/Glaucoma
☐	☐	Wear glasses/contact lens
☐	☐	Blurred or double vision

EAR/NOSE/MOUTH/THROAT

Yes	No	
☐	☐	Nose or gum bleeds
☐	☐	Mouth sores
☐	☐	Bad breath or bad taste

CARDIOVASCULAR

Yes	No	
☐	☐	Chest pain or angina
☐	☐	Palpitation
☐	☐	Swelling of feet, ankles

RESPIRATORY

Yes	No	
☐	☐	Chronic or frequent cough
☐	☐	Spitting up blood
☐	☐	Shortness of breath
☐	☐	Asthma or wheezing
☐	☐	Sleep Apnea

GENITOURINARY

Yes	No	
☐	☐	Frequent urination
☐	☐	Burning or painful urination
☐	☐	Blood in urine
☐	☐	Prostate problems
☐	☐	Last menstrual period __________

MUSCULOSKELETAL

Yes	No	
☐	☐	Joint pain/stiffness
☐	☐	Back pain
☐	☐	Arthritis

INTEGUMENTARY (skin, breast)

Yes	No	
☐	☐	Rash or itching
☐	☐	Change in hair
☐	☐	Change in nails
☐	☐	Unusual moles

NEUROLOGICAL

Yes	No	
☐	☐	Headaches/Dizziness
☐	☐	Alzheimer's/Dementia
☐	☐	Convulsions/Seizures
☐	☐	Depression/Stress

ENDOCRINE

Yes	No	
☐	☐	Hormone problem
☐	☐	Thyroid disease
☐	☐	Excessive thirst

PAST SURGICAL HISTORY

Have you **ever had** any of the following types of surgery:

Yes	No	
☐	☐	Colon surgery/Colonoscopy
☐	☐	Appendix
☐	☐	Gallbladder
☐	☐	Hysterectomy
☐	☐	Tonsils
☐	☐	Hiatal Hernia
☐	☐	Hernia/Groin
☐	☐	Bilateral Tubal Ligation
☐	☐	Back surgery
☐	☐	Prostate
☐	☐	Breast surgery
☐	☐	Joint replacement __________
☐	☐	Laparoscopy
☐	☐	Hemorrhoids
☐	☐	Heart bypass/Stent
☐	☐	Blood transfusion
☐	☐	Other __________

CHRONIC DISEASE

Have you **ever had** any of these problems:

Yes	No	
☐	☐	Exposure to HIV/AIDS
☐	☐	Ulcers
☐	☐	Colon trouble
☐	☐	Colitis
☐	☐	Diverticulitis
☐	☐	Pancreatitis
☐	☐	Alcoholism
☐	☐	Heart attack/Disease
☐	☐	Stroke
☐	☐	High blood pressure
☐	☐	Diabetes
☐	☐	Tuberculosis
☐	☐	Emphysema
☐	☐	Depression
☐	☐	Arthritis
☐	☐	Kidney trouble
☐	☐	Prostate
☐	☐	Cancer __________
☐	☐	Type __________

OFFICE USE ONLY

LOCATION, SEVERITY, TIMING, ASSOCIATED SIGNS/SX, QUALITY, DURATION, CONTEXT (WHERE/WHEN), MODIFYING FACTORS

____
____
____
____
____
____
____
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____
____

▶ *PATIENT INFORMATION continued…*

FAMILY HISTORY

Has any blood relative had any of these problems:

Yes	No		Yes	No		Yes	No	
☐	☐	Colon cancer	☐	☐	GYN cancer	☐	☐	Stroke
☐	☐	Colon polyps	☐	☐	Gallbladder disease	☐	☐	Sickle Cell disease
☐	☐	Cirrhosis	☐	☐	Ulcer disease	☐	☐	Tuberculosis
☐	☐	Hepatitis	☐	☐	Diabetes	☐	☐	Mental illness
☐	☐	Alcoholism	☐	☐	High blood pressure	☐	☐	Prostate cancer
☐	☐	Breast cancer	☐	☐	Heart attack	☐	☐	Other cancer ____________

SOCIAL HISTORY

☐ Married ☐ Single ☐ Widow ☐ Divorced

Yes	No		Yes	No	
☐	☐	Do you smoke? Packs per day _______________	☐	☐	Homosexual/bisexual?
☐	☐	Do you drink alcohol? How much? ____________	☐	☐	More than one sex partner?________________
☐	☐	Do you drink coffee? Cups per day ____________	☐	☐	Used IV drugs or cocaine ________________
			☐	☐	Tattoos, body piercings

LIST THE NAME AND DOSAGE OF ALL MEDICINES YOU TAKE NOW

Yes	No		Yes	No	
☐	☐	High blood pressure________________________	☐	☐	Antihistamines ______________________
☐	☐	Stomach medicines ________________________	☐	☐	Hormones/birth control ________________
☐	☐	Laxatives ________________________________	☐	☐	Diabetic medication-Insulin/oral____________
☐	☐	Sleeping pills _____________________________	☐	☐	Asprin, Advil, Ibuprofen, pain pills, etc. ________
☐	☐	Tranquilizers _____________________________	☐	☐	Arthritis medicines ____________________
☐	☐	Thyroids_________________________________	☐	☐	Heart ______________________________
☐	☐	Antibiotics _______________________________	☐	☐	Other ______________________________
☐	☐	Blood thinners (Coumadin, Lovenox, Plavix, Persantine (Dipyridamole) Ticlid ______________			

Patient's Signature ____ Date______________

MD Signature____ Date______________

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