Gastroenterology Associates, PA

Click here to print

1165 Park Avenue Plainfield, NJ 07060
Phone: (908) 754-2992 **Fax (908) 754-8366**

Allan B. Cohen, M.D., F.A.C.G.
Diplomate of the American Boards of Internal Medicine and Gastroenterology

David A. Goldenberg, M.D., F.A.C.G
Diplomate of the American Boards of Internal Medicine and Gastroenterology

Name: **DOB:** **Date:**

HISTORY - COMPLETED BY PATIENT

1. Reason for your visit today_____

_____

_____

_____

(use area on page two or other side for additional information)

2. Please indicate if you are having any current problems signs or symptoms in any of the following areas:
√

- ☐ General Wellness
- ☐ Eyes
- ☐ Ears, Nose, Throat
- ☐ Skin
- ☐ Stomach/Digestion
- ☐ Lungs/Breathing
- ☐ Heart/Circulation
- ☐ Mentrual/Reproductive
- ☐ Neurological
- ☐ Kidney/Urinary
- ☐ Thyroid/Endocrine
- ☐ Blood/Lymph
- ☐ Muscles/Joints/Bones
- ☐ Psychiatric
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Arthritis
- ☐ Other medical conditions

Comments – (use back or comment section for additional space)

3: Please list all previous hospitalizations and surgeries, with dates, and any other past medical conditions:

4. Current Medication(s) (drugs, pills, aspirin, blood thinners, vitamins, herbs, supplements)

5. Allergies(medications, X-ray contrast, foods, etc):

Gastroenterology Associates, PA

Patient History Form – page two

6. What is your Social History?

Marital Status: Single □, Divorced □, Married □, Widow/Widower □, Who lives with you?_____

Current Occupation/Employer _____What kind of work?_____

Do you smoke? _____ How many packs a day? _____ For how many years? _____

Do you drink alcohol?_____ How many drinks per day?_____ per week?_____ per month?_____

---

7. What is the Health Status of Your Family?

Mother: □ Living? □ Deceased? If deceased: age at & cause of death _____

Medical conditions:_____

Father: □ Living? □ Deceased? If deceased: age at & cause of death _____

Medical conditions:_____

Brothers/Sisters: □ #Living? □ #Deceased If deceased: age at & cause of death _____

Medical conditions:_____

Family Illnesses:

Colon cancer or polyps □ yes □ no If yes: relationship: _____

Inflammatory Bowel disease (Ulcerative colitis or Crohn's disease): □ yes □ no If yes: relationship : _____

Other Gastrointestinal disorders : □ yes □ no If yes: relationship _____

Condition(s) (if known): _____

History of Heart Disease (heart attack, heart failure) □ yes □ no History of strokes? □ yes □ no

History of high blood pressure? □ yes □ no History of diabetes? □ yes □ no History of cancer? □ yes, site _____ □no

8. Comments or additional information: