

IBERIA GASTROENTEROLOGY ASSOCIATES

NAME _____ DOB _____ AGE _____ DATE _____

If you have been diagnosed with any new medical conditions, had any surgery, or been hospitalized since your last office visit with Dr. Stokes, please list below.

If you have started any new medications or changed any of your medications since your last office visit, please list below.

Please check Yes or No to the following medical problems

<u>CONSTITUTIONAL</u>	yes	no	<u>URINARY</u>	yes	no	<u>NEUROLOGICAL</u>	yes	no
<u>Weight Loss</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Difficulty urinating</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Clumsiness</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Lack of energy</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Blood in Urine</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Numbness of arms or feet</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Weakness</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Control of urine</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Difficulty Walking</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>EYES</u>			<u>MUSCULOSKELETAL</u>			<u>INTEGUMENTARY</u>		
<u>Change in your vision</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Back Pain</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Rashes</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Glasses or Contacts</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Muscle Cramps</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Itching</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>ENT</u>			<u>Joint Pain</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Hair Loss</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Nasal Congestion</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>GASTROINTESTINAL</u>			<u>Breast Discharge</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Nosebleeds</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Abdominal Pain</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>PSYCHIATRIC</u>		
<u>Hoarseness</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Nausea/Vomiting</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Mood Changes</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Mouth Sores</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Gas/Bloating</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Depression</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Hearing Loss</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Heartburn</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Anxiety</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>CARDIOVASCULAR</u>			<u>Loss of Appetite</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>HEMATOLOGIC/LYMPHATIC</u>		
<u>Chest Pain</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Trouble Swallowing</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Easy bruising or bleeding</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Palpitations of the Heart</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Black Stools</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>ENDOCRINE</u>		
<u>Fainting</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Diarrhea</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Always Thirsty</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Dizziness</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Constipation</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Urinating Frequently</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Swelling</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Rectal Bleeding</u>	<input type="checkbox"/>	<input type="checkbox"/>			
<u>PULMONARY</u>			<u>Change in Bowel Habits</u>	<input type="checkbox"/>	<input type="checkbox"/>			
<u>Shortness of Breath</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>ALLERGY</u>					
<u>Coughing</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Allergies</u>	<input type="checkbox"/>	<input type="checkbox"/>			
<u>Chest Tightness</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Sneezing</u>	<input type="checkbox"/>	<input type="checkbox"/>			

PATIENT'S SIGNATURE _____ NURSE'S SIGNATURE _____