



**Kamloops
Gastroenterology
Associates**

New Patient Intake Form

NAME: _____ DATE: _____

Reason for your visit to the office:

Symptoms (within last 6 months)	No	Yes	Comments
Trouble swallowing			
Heartburn			
Nausea or vomiting			
Abdominal pain			
Jaundice (yellow skin)			
Diarrhea or constipation			
Change in bowel habits			Frequency:
Rectal bleeding			
Unexplained weight loss			

Medical History	No	Yes	Comments
Gastrointestinal (eg ulcers, GERD, Barrett's, colitis)			
Previous gastroscopy or colonoscopy			
Surgery (eg abdominal and other)			
Cardiac (eg A. Fib, pacemaker, heart attack)			
Respiratory (eg sleep apnea, asthma, COPD)			
Liver			

Kidney			
Diabetes			
Stroke			
Cancer			
Bleeding disorder			
Blood transfusion concerns (eg Jehovah's witness)			
Allergies			

Social History	No	Yes	Comments
Do you live with anybody?			
Are you working/in school?			
Do you smoke?			Approx quit date:
Do you drink alcohol?			Drinks per week:
Do you use any other substances?			

Family History	No	Yes	Comments
Colon cancer			
Cancer of stomach/esophagus			
Liver disease or cirrhosis			
Crohn's or ulcerative colitis			
Celiac disease			

Medications you are taking	Comments