

T.M. KALRA, M.D.
A PROFESSIONAL CORPORATION

GASTROENTEROLOGY HISTORY & PHYSICAL

DATE: _____

NAME: _____

DATE OF BIRTH: _____

RECENT HISTORY:

GASTROINTESTINAL Y N

Alcoholism		
Abdominal Pain		
Right upper abdominal		
Right lower abdominal		
Left upper abdominal		
Left lower abdominal		
Mid-Upper abdominal		
Black Stool		
Constipation		
Crohn's Disease		
Diarrhea		
Heartburn		
Jaundice		
Kidney Disease		
Liver Disease		
Nausea or Vomiting		
Pancreas Disease		
Rectal Bleeding		
Trouble Swallowing		
Ulcers - Stomach & Duodenal		

HABITS Y N

Smokes		
how long?		
Alcohol		
how many drinks per wk?		
Diet		
(i.e.. Low-carb/fat)		
Exercise		
frequency?		

MEDICAL HISTORY:

CARDIAC Y N

Chest Pain / Angina		
Congenital heart disease		
Congestive heart failure		
Heart attack/Stent/Bypass		
Heart rhythm disturbance		
Heart valve replacement/disease/infection		
High Blood Pressure (Hypertension)		
History use of Coumadin or Blood thinners		
High Cholesterol		

PULMONARY Y N

Asthma		
Cough/Bronchitis		
COPD		
History of Sleep Apnea		

HEMATOLOGY Y N

Anemia		
Blood disorders or easy bruising		

ENDOCRINE Y N

Diabetes		
Menstrual Problems		
Thyroid Problems		

PSYCHOLOGICAL Y N

Anxiety		
Depression		

Y N

Cancer		
Type?		

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MEDICATION LIST

Name: _____

DO YOU TAKE BABY ASPIRIN DAILY?	Yes / No
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Medication	Dosage	Frequency	Start Date	End date

Allergies to medications:

Surgeries and Previous Procedures:

Family History: