THE GASTROENTEROLOGY GROUP
DOUGLAS J. SPRUNG, M.D., F.A.C.G., F.A.C.P.

Date

Name ______ Age ______ Birth Date ______

Occupation ______ Referred By ______

Date of Last Physical Exam ______

Chief Complaint (reasons for coming to doctor): ______

Medications you are allergic to: ______

Medications that you are currently taking : ______

Immunizations (date last given): Tetanus ______ Pneumonia ______

Influenza ______ Other ______

List Hospitalizations, Operations and Injuries:

Year	Reason	Hospital

Tests: (please give dates)

Chest X-Ray ______

Upper GI Series ______

Barium Enema ______

Proctoscopy ______

Gall Bladder X-Ray ______

Cardiogram ______

Others ______

Do you smoke? ______ # Years ______ # Packs/Day ______ When did you quit? ______

Do you drink alcoholic beverages? ______ Estimated amount/day ______

Do you drink coffee? ______ Tea? ______ Cups per day ______

Specify any foreign travel in the past 10 years ______

Food intolerances ______

Are you overweight? ______ By how many pounds? ______ Exercise/Kind/Times per week: ______

Family History	Alive	Dead	Age	Medical Problems
Father				
Mother				
Brothers/Sisters				
Spouse				
Children				

Other Relatives History

	Heart Attacks
	Heart Failure
	Stroke
	Hypertension
	Diabetes
	Ulcer Disease
	Colonic Polyps
	Colon Cancer
	Other Cancers

PAST MEDICAL HISTORY: Place an (X) in the box in front of a past problem.

	Hypertension		Jaundice		Genital Herpes		Anemia
	Heart Attacks		Cancer		Nervous Disorders		Bleeding Problem
	Heart Failure		Asthma		Epilepsy		Arthritis
	Angina		Emphysema		Depression		Phlebitis
	Diabetes		Rheumatic Fever		Glaucoma		Kidney Stones
	Ulcers Gastric/Duodenal		Tuberculosis		Stroke		Urinary Tract Inf.
	Liver Disease		Syphilis		Blood Transfusions		Colitis
	Hepatitis		Gonorrhea		Pneumonia		Colonic Polyps

SYSTEMS REVIEW:

	Poor Appetite		Nose Bleeds		Difficulty Swallowing
	Weight Loss		Hoarseness		Heart Burn
	Weight Gain		Sinus Trouble		Indigestion
	Thyroid Disease		Ear Infections		Nausea
	Fatigue		Trouble Smelling		Vomiting
	Weakness		Frequent Colds		Belly Pain
	Fever/Chills		Gum Disease		Diarrhea
	Night Sweats				Constipation
	Skin Changes		Frequent Cough		Blood in Stools
	Excess Body Hair		Sputum		Black Stools
	Heat or Cold Intolerance		Wheezing		Vomiting Blood
	Poor Concentration		Shortness of Breath		Bloating
	Poor Memory		Cough Up Blood		Belching
	Early Morning Awakening		Tuberculosis Exposure		Flatulence (Gas)
	Depression				Rectal Pain
	Crying Spells		Palpitations		Mucus in Stools
			Shortness of Breath/Exercise		Hemorrhoids
	Head Aches		2 or More Pillows		Change in Bowel Habits
	Blurred Vision		Ankle Swelling		
	Double Vision		Heart Murmur		Frequent Urination
	Blind Spots		Fainting		Void at Night
	Hearing Difficulty		Enlarged Heart		Burning with Urination
	Ringing in Ears		Chest Pain		Hesitancy
	Dizziness		Wake Up Short of Breath		Incontinence
			Varicose Veins		Blood in Urine
	Convulsions		Leg Cramps		Impotence
	Loss of Consciousness				
	Paralysis		Muscle Weakness		Arthritis
	Numbness		Muscle Pain		Gout
	Back Aches		Muscle Spasm		Others

WOMEN:

	Irregular Periods		Last Period:
	Severe Cramping		Last Pelvic Exam:
	Hot Flashes		Last Pap Test:
	Vaginal Discharges		Result:
	Vaginal Bleeding/Spotting		Last Mammogram:
	Breast Lump or Discharge		Result:
	Pain with Intercourse		

THE
GASTROENTEROLOGY
GROUP

DOUGLAS J. SPRUNG, M.D., F.A.C.G., F.A.C.P.

DIPLOMATES OF THE AMERICAN BOARD OF
INTERNAL MEDICINE IN MEDICINE AND
GASTROENTEROLOGY

Patient Name: ________________________________ Date: _______________

MEDICATION LIST

PRESCRIPTIONS

MEDICATION	DOSAGE OR STRENGTH	TIMES TAKEN DAILY

OVER THE COUNTER MEDICATIONS/VITAMINS/SUPPLEMENTS/HERBS

MEDICATION	DOSAGE OR STRENGTH	TIMES TAKEN DAILY

205 LORAINE DR. • ALTAMONTE SPRINGS, FLORIDA 32714
TELEPHONE: 407-261-0000 • FAX: 407-261-1000