Francisco Baigorri, M.D.
Gustavo Calleja, M.D.
Daniel Gelrud, M.D.
Harris I. Goldberg, M.D.
James Leavitt, M.D.
Marc Lederhandler, M.D.
Javier L. Parra, M.D.
Alfredo Rabassa, M.D.
S. Lawrence Rothman, M.D.
Eduardo A. Ruan, M.D.

Howard I. Schwartz, M.D.
Arie Slomianski, M.D.
Stefania Vernace, M.D.
Darlene Boytell-Perez, A.R.N.P.
Ellen Matas-Sosa, P.A.-C.
Raisa Miller, P.A.-C.
Hernando Mispireta, A.R.N.P.
Hengameh Shahidpoor, A.R.N.P.

John P. Christie, M.D.
Outpatient Colorectal Surgery

Welcome to our practice! At GI Care Center, we strive to provide excellence in gastroenterology care. We have highly trained and knowledgeable staff committed to making your visit as comfortable as possible. Please assist us by reading the following instructions and completing all forms in advance of your appointment.

Please remember to arrive 30 minutes before your scheduled appointment time with the following documents:

1. Completed New Patient Packet forms:
   - Medical & Family History Form
   - Signed Consent for Purposes of Treatment, Payment, and Healthcare

2. A photo ID

3. Insurance card(s)

4. A referral, issued by your primary care physician, if required by your insurance

5. Any test or medical results that pertain to your visit, especially blood work/lab results

6. A list of current medications you are taking

7. The name and telephone number of your pharmacy

Please call the office as soon as possible if you are unable to keep your appointment or are going to be late.

Once again, welcome to our practice. We look forward to providing you with quality care.

Galloway Medical Park • 7500 S.W. 87th Avenue • Suite 200 • Miami, FL 33173
South Miami Office • 6141 Sunset Drive • Suite 301 • Miami, FL 33143
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GASTRO HEALTH

7500 SW 87th Avenue
Suite 200
Miami, FL 33173
305-913-0666

MEDICAL & FAMILY HISTORY FORM

NAME: ______________________ TODAY'S DATE: ______________________
CHART NO: ______________________ DATE OF BIRTH: ______________________
REASON FOR VISIT: ______________________

Allergies:
❑ NONE ❑ Aspirin ❑ Codeine ❑ Eggs ❑ Iodine ❑ Morphine ❑ Penicillin ❑ Sulfa ❑ Versed ❑ Valium ❑ Other: ______________

Past or Present Medical Problems:

❑ Anemia
❑ Arthritis
❑ Asthma
❑ Cancer __________
❑ Cataracts
❑ Celiac Disease
❑ Chronic anxiety
❑ Chronic cough
❑ Chronic lung disease
❑ Chronic sinusitis
❑ Cirrhosis of liver
❑ Colon cancer
❑ Colon polyps
❑ Crohn's disease
❑ Diabetes
❑ Diverticulitis
❑ Ear infections
❑ Emphysema
❑ Fatty liver
❑ Frequent urinary infections
❑ Gallstones
❑ Glaucoma
❑ Gonorrhea
❑ Gout
❑ Groin Hernia
❑ Heart attack
❑ Heart Murmur
❑ Hemorrhoids
❑ Hepatitis
❑ Hiatal Hernia
❑ High blood pressure
❑ High cholesterol
❑ High triglycerides
❑ HIV/AIDS
❑ Irregular heart beat
❑ Irritable bowel syndrome
❑ Kidney disease/failure
❑ Kidney infection
❑ Kidney stones
❑ Lupus
❑ Migraines
❑ Milk intolerance
❑ Multiple Sclerosis
❑ Osteoporosis
❑ Ovarian cyst
❑ Pancreatitis
❑ Paralysis
❑ Parkinson's Disease
❑ Phlebitis
❑ Pneumonia
❑ Polio
❑ Psoriasis
❑ Reflux
❑ Rheumatic fever
❑ Sciatica
❑ Seizures
❑ Sexually transmitted disease
❑ Skin cancer
❑ Sleep Apnea
❑ Stomach/duodenal ulcer
❑ Stroke
❑ Syphilis
❑ TB (Tuberculosis)
❑ TB skin test positive
❑ Thyroid disease
❑ Ulcerative colitis

Surgeries/Hospitalization/Procedures:

❑ NONE
❑ Appendectomy
❑ Breast __________
❑ Cardiac surgery
❑ Cataract surgery
❑ Colon Resection
❑ Colonoscopy
❑ Colostomy
❑ C-section
❑ EGD
❑ ERCP
❑ Gallbladder surgery
❑ Groin Hernia
❑ Hemorrhoid surgery
❑ Hiatal Hernia
❑ Hysterectomy
❑ Joint replacement
❑ Kidney _______
❑ Liver Biopsy
❑ Obesity surgery
❑ Ovary surgery
❑ Prostate_____
❑ Stomach______
❑ Thyroid______
❑ Tonsillectomy
❑ Tubal Ligation
❑ Uterus_______
❑ Other _______
____
____

Social History Marital Status:
❑ Single ❑ Separated ❑ Married
❑ Divorced ❑ Widowed

Social History Recreational Drugs:
❑ I have never used recreational drugs
❑ I have used recreational drugs in the past
❑ I am currently using recreational drugs
❑ I have been treated for substance abuse

Social History Alcohol:
❑ Never ❑ More than 2 days/week
❑ Rarely ❑ Less than 2 days/week
❑ Daily ❑ I quit using alcohol

Social History Tobacco:
❑ I use tobacco products
❑ I quit using tobacco products
❑ I have never used tobacco products

Social History Occupation:
Patient occupation: ______________________ ❑ Veteran

Social History Hobbies:
Patient hobbies: ______________________

Gastrointestinal:

❑ NONE
❑ Abdominal Pain
❑ Belching
❑ Bloating
❑ Blood in stool
❑ Change in bowel habits
❑ Constipation
❑ Diarrhea
❑ Fat intolerance
❑ Heartburn
❑ Hemorrhoids
❑ Jaundice
❑ Nausea
❑ Rectal bleeding
❑ Soiling/incontinence
❑ Trouble swallowing
❑ Vomiting
❑ Other ______________
____
____

Genitourinary:
❑ NONE
❑ Blood in urine
❑ Change in urinary frequency
❑ Sexual difficulty
❑ Other ______________

MALE
❑ Prostate problem
❑ Testicle problem

FEMALE
❑ Heavy periods

Skin:
❑ NONE
❑ Nodules
❑ Rash
❑ Tattoos
❑ Itching
❑ Recurrent boils
❑ Skin infections
❑ Other ______________

Cardiovascular:
❑ NONE
❑ Abnormal EKG
❑ Angina/chest pain w/activity
❑ Enlarged Heart
❑ Pacemaker
❑ Pain in legs w/walking
❑ Shortness of breath with exercise
❑ Swelling in the legs
❑ Varicose veins
❑ Other ______________________

Neurological:
❑ NONE
❑ Chronic numbness/tingling
❑ Dizziness/lightheadedness
❑ Headaches
❑ Weakness in arms
❑ Weakness in legs
❑ Other: ________________

Constitutional:
❑ NONE
❑ Chills
❑ Fatigue
❑ Fever
❑ Night sweats
❑ Poor appetite
❑ Sweats
❑ Weight gain
❑ Weight loss
❑ Other ________________

Eyes:
❑ NONE
❑ Blindness
❑ Change in vision
❑ Inflammation
❑ Poor vision
❑ Other: ________________

Ears, Nose and Throat:
❑ NONE
❑ Bleeding gums
❑ Chronic sinus problems
❑ Congestion
❑ Hearing loss
❑ Hoarseness
❑ Mouth sores
❑ Nose bleeds
❑ Ringing in ears
❑ Other ________________

Respiratory:
❑ NONE
❑ Chronic cough
❑ Cough up blood
❑ Other: ________________

Endocrine:
❑ NONE
❑ Abnormal growth of hair
❑ Abnormal loss of hair
❑ Abnormally hot
❑ Abnormally cold
❑ Excessive thirst
❑ Goiter
❑ Breast enlargement or pain
❑ Hot flashes
❑ Other: ________________

Psychiatric:
❑ NONE
❑ Abnormal sleep
❑ Anxiety
❑ Emotional problems
❑ Memory loss/confusion
❑ Nervous breakdown
❑ Other:________________

Hematologic:
❑ NONE
❑ Bleeding doesn't stop easily
❑ Enlarged glands
❑ Frequent bruising
❑ Thrombosis/blood clots
❑ Transfusion
❑ Other:________________

Musculoskeletal:
❑ NONE
❑ Back pain
❑ Broken bones
❑ Chronic stiff joints ________
❑ Disc problem
❑ Swollen joints
❑ Other:________________

Immunizations:
❑ NONE
❑ Flu
❑ Hepatitis A
❑ Hepatitis B
❑ Pneumonia
❑ Other: ________________

Medications:
❑ NONE
❑ Aciphex
❑ Analpram
❑ Anusol
❑ Asacol
❑ Axid
❑ Bentyl
❑ Carafate
❑ Donnatal
❑ Lactulose
❑ Lomotil
❑ Nexium
❑ NuLev
❑ Pentasa
❑ Pepcid
❑ Prednisone
❑ Prevacid
❑ Prilosec
❑ Protonix
❑ Questran
❑ Remicade
❑ Rowasa
❑ Tagamet
❑ Zantac
❑ Other ____

Current Medications:
Please list any prescription or over the counter medications you are currently taking on the lines below:

____ ____
____ ____
____ ____
____ ____

Family History:

	Father	Mother	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Deceased	❑	❑	❑	❑	❑	❑	❑	❑
Healthy	❑	❑	❑	❑	❑	❑	❑	❑
Alcoholism	❑	❑	❑	❑	❑	❑	❑	❑
Arthritis	❑	❑	❑	❑	❑	❑	❑	❑
Birth Defects	❑	❑	❑	❑	❑	❑	❑	❑
Bleeding Tendency	❑	❑	❑	❑	❑	❑	❑	❑
Cancer (type)	❑______	❑______	❑______	❑______	❑______	❑______	❑______	❑______
Colitis age at diagnosis	❑______	❑______	❑______	❑______	❑______	❑______	❑______	❑______
Colon Cancer age at diagnosis	❑______	❑______	❑______	❑______	❑______	❑______	❑______	❑______
Colon Polyps	❑	❑	❑	❑	❑	❑	❑	❑
Crohn's Disease	❑	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑
Heart Trouble	❑	❑	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑	❑	❑
Liver Disease	❑	❑	❑	❑	❑	❑	❑	❑
Lung Disease	❑	❑	❑	❑	❑	❑	❑	❑
Stomach Cancer	❑	❑	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑	❑	❑
TB	❑	❑	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑	❑	❑
Ulcer Disease	❑	❑	❑	❑	❑	❑	❑	❑
Other	❑______	❑______	❑______	❑______	❑______	❑______	❑______	❑______