THINGS TO REMEMBER TO ASK MY DOCTOR

1. What is my main problem? _________________________________________________________
2. What do I need to do? ____________________________________________________________
3. Why is it important for me to do this? ______________________________________________
4. When will I start to feel better? ___________________________________________________
5. Other notes ______________________________________________________________________
In the past 3 years have you had a:

<table>
<thead>
<tr>
<th>Substance</th>
<th>Current Use</th>
<th>Previous Use</th>
<th>Type/Amount</th>
<th>If stopped when</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stool tested for blood</td>
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<tr>
<td>Flex-sigmoidoscopy</td>
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<tr>
<td>Upper endoscopy</td>
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<tr>
<td>Colonoscopy</td>
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<tr>
<td>Blood cholesterol level</td>
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<tr>
<td>Prostatic specific antigen test (PSA)</td>
<td></td>
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<tr>
<td>Caffeine (coffee, tea, soda)</td>
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</tr>
<tr>
<td>Tobacco</td>
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<tr>
<td>Alcohol (beer, wine, liquor)</td>
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<tr>
<td>Recreational/street drugs</td>
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</tbody>
</table>

Have you used any of the following substances?

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<th>Type/Amount</th>
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</table>

Disability – Are you disabled? □ No □ Yes If yes, cause:

Have you used any of the following substances?

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<th>Type/Amount</th>
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<td>Recreational/street drugs</td>
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</table>

Marital Status: □ Single □ Separated □ Divorced □ Widowed (list cause of death)

Marital Status: □ Married (list any health problems)

Spouse’s current employment status: □ retired □ unemployed □ homemaker □ employed

Spouse’s current occupation:

FAMILY HISTORY Some names may be used for either men or women, please indicate sex for each brother, sister, son or daughter. You may omit names.

<table>
<thead>
<tr>
<th>IF LIVING</th>
<th>IF DECEASED</th>
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</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
</tr>
<tr>
<td>Siblings</td>
<td></td>
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<tr>
<td>Spouse/Partner</td>
<td></td>
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<tr>
<td>Children</td>
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</tbody>
</table>

It is very important for your health that you answer these questions as completely and accurately as you can. If you do not understand something, please ask us for help.

We want you to live a healthier life.
**Do you know of any blood relative who has or had:** (Check all that apply and give relationship to you)

- Breast cancer
- Ovarian cancer
- Esophageal cancer
- Gastric cancer
- Rheumatologic/Autoimmune disease
- Epilepsy
- Liver disease
- Heart disease
- Mental illness
- Lung disease
- Ulcer (duodenal or gastric)
- Crohn’s disease
- Stroke/TIA
- Arthritis
- Other cancer
- High cholesterol/triglycerides
- Migraine
- Kidney disease
- Diabetes
- Alcohol or Drug abuse
- Genetic disorder
- Goiter
- Irritable bowel syndrome
- High blood pressure

**REVIEW OF SYSTEMS:** Do you have, or have you had, any of the following problems?

**General:**
- Poor appetite
- Weight loss
- Weight gain
- Easy fatigability
- Fever or abnormal sweating

**Skin:**
- Itching
- Rash
- Yellowing

**Hematological:**
- Easy bruising
- Blood clots
- Enlarged lymph nodes
- Transfusion

**Head:**
- Eye trouble
- Hearing disorder
- Sore tongue or mouth
- Yellow eyes
- Snoring

**Neck:**
- Goiter
- Lumps or masses

**Chest:**
- Chest pain
- Shortness of breath
- Palpitations
- Asthma
- Chronic cough
- High blood pressure

**GI:**
- Heart burn
- Difficulty swallowing
- Indigestion
- Milk intolerance
- Persistent nausea or vomiting
- Vomiting blood
- Passing blood
- Abdominal pain
- Diarrhea
- Constipation
- Abdominal swelling

**GU:**
- Difficulty with urination
- Blood in urine
- Dark urine
- Kidney stones

**Females Only:** Any difficulty with menstrual periods?
- No
- Yes
- Last menstrual period: ______/______/_______

**Contraceptive use:**
- Estrogen replacement?
- No
- Yes

**Extremities:**
- Arthritis
- Swollen legs
- Cold sensitivity
- Muscle pain

**Neurological:**
- Recurrent headaches
- Loss of consciousness
- Seizures
- Loss of memory
- Confusion
- Tremor
- Weakness or numbness of face or extremities
- Psychological depression
- Anxiety

**Current Medications** – List all medications you take. Include how much and how often.

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose/Frequency</th>
<th>Name</th>
<th>Dose/Frequency</th>
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</thead>
<tbody>
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</tbody>
</table>

**Allergies – Have you had any allergy to any medications?**
- No
- Yes,

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Reaction</th>
<th>Name</th>
<th>Type of Reaction</th>
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<tbody>
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Reviewing Physician: ______________________ Date: ______________________

Your healthcare is very important to us.

Thank you for choosing
Johns Hopkins Hospital Division of Gastroenterology.
Outpatient Medication List

Directions: Update and give a copy of this list to the patient with each outpatient visit. Do not use abbreviations.

☐ Patient taking no medication regularly and none in the past 72 hours.

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSE</th>
<th>ROUTE</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Vitamin C</td>
<td>250 mg</td>
<td>By mouth</td>
<td>Once a day</td>
</tr>
</tbody>
</table>

1.
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14.

New Medications – Please enter all new medications below.

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSE</th>
<th>ROUTE</th>
<th>FREQUENCY</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<tr>
<td>4.</td>
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</tbody>
</table>

Please use additional sheet for more medications.

Reviewed by (Name and credentials of health care provider) / / Time

If you have questions about any of your medications, please contact the person who prescribed them.