ILLINOIS GASTROENTEROLOGY, LTD.

NAME: ________________________________DATE: ___________________________

REASON FOR VISIT: ____

PATIENT Illness/Surgery   Year

___________________   _____

___________________   _____

___________________   _____

___________________   _____

___________________   _____

FAMILY History

Disease   Relationship

- ☐ Cancer __________
- ☐ Colon Polyps __________
- ☐ Ulcer __________
- ☐ Liver Disease __________
- ☐ Pancreatitis __________
- ☐ Other __________

Do you smoke? ☐ Yes ☐ No

Packs per day: _________
Years smoked: _________

Do you use alcohol? ☐ Yes ☐ No
drinks per week: ____________

MEDICINES: (List all prescriptions over-the-counter drugs, vitamins, herbal, etc.):

____
____
____
____
____
____
____
____
____

ALLERGIES:
Drug: ______________________
____
____
Other: ______________________
____