Patient History

Buffalo Gastroenterology Associates, LLP

Name: _____ Date of Birth _____

Please list all MD's you see currently and Gastroenterologists you have seen in the past

MD's Name	Address	Phone Number
1)		
2)		
3)		

Previous Illnesses/Hospitalizations:	Previous Surgeries & Date:
1)	1)
2)	2)
3)	3)
4)	4)
5)	5)

Medications: Name / Dosage / Frequency:

1)	1)
2)	2)
3)	3)
4)	4)
5)	5)

Medication Allergies:

1)	Smoking History
2)	Alcohol History
3)	Tattoos
4)	Intravenous Drug Use
5)	Body Piercing

Family History

	Mother	Father	Sibling	Sibling	Sibling	Grand parents	Children	Other
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐	☐	☐
Pancreatic Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Stomach Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Peptic ulcer	☐	☐	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐	☐	☐
Colitis	☐	☐	☐	☐	☐	☐	☐	☐
Gallstones	☐	☐	☐	☐	☐	☐	☐	☐