Gastroenterology and Hepatology

Stephen P. Laird, MD, MS

Allisa R. Corsbie, NP-C

Name:__________________________ Sex: M F Age:_______ Date:___________

Referring Physician: ______________________ Primary Care Physician:___________________________

*I Authorize CMM, P.C to leave a phone message with my medical results: Yes No Phone#:________________

*I Authorize CMM, P.C to send a message to my Follow My Health portal account: Yes No

Reason for Visit Today: ____

Other Providers Seen for this Issue: ____

History of Present Illness:

Have you been diagnosed with any of the following:

Cancer:	Yes No	Type/ Date:________________________________
Colon Polyps:	Yes No	Type/ Date: _______________________________
Crohn's Disease:	Yes No	Date/ Date of Last Colonoscopy: _______________
Esophagitis/ Barrett's:	Yes No	Date/ Last EGD:_____________________________
Gallstones:	Yes No	Date/Evaluation/Treatment: __________________
Hiatal Hernia/ GERD:	Yes No	Date:______________________________________
Ulcers:	Yes No	Date:______________________________________
Ulcerative Colitis:	Yes No	Date/ Last Colonoscopy: _____________________

Do you have any of the following:

History of MRSA: Yes No	Heart Problems/ Chest Pain: Yes No	Stroke:Yes No
High/Low Blood Pressure: Yes No	Kidney Disease: Yes No	Tuberculosis: Yes No
Diabetes: Yes No	Lung Disease: Yes No	Bleeding Disorder: Yes No
Epilepsy/ Seizures: Yes No	Thyroid Problems: Yes No	Other:______________

Please continue to back page

Other History: (If yes please write the date and location on the black space)

Colonoscopy:____

EGD:____

MRCP/ MRI/ CT scan: ____

Problems with Anesthesia or Contrast Dye:____

Surgical History: (If yes please write date and location/ facility on the black space)

Colon:_______________ Stomach:__________________ Heart:__________________

Stent/Bypass:__________ Valve:_____________________ Pacemaker:______________

Defibrillator:___________ Joint Replacement:___________ Hysterectomy:____________

Appendectomy:_________ Prostate:___________________ Bladder:__________________

Other:__________________ Other:_____________________ Other:____________________

Social History:

Marital Status:___________________________ Occupation:______________________________________

Tobacco Use: Yes No Quit:_______________ Alcohol Use: Yes No Quit:_________________________

Marijuana Use: Yes No Quit:_____________ Substance Use: Yes No Quit:______________________

Tattoos: Yes No Blood Transfusions: Yes No

Family History: (Please indicate any Relatives with the following. If yes, who?)

Alcoholism/ Cirrhosis/ Jaundice: ____

Colon Cancer/ Colon Polyps:____

Crohn's Disease/ Ulcerative Colitis: ____

Heart Disease/ High Blood pressure: ____

Gallstones:______________________________ Diabetes:____

Liver Disease:___________________________ Hemochromatosis: _________________________________

Peptic Ulcer:____________________________ Other:____

Physician/ NP-C Signature: ____ Date:___________________