GI ASSOCIATES OF DELAWARE, P.A.
Natwarlal Ramani, M.D.
Jatan Raythatha, PA-C

742 S. Governors Avenue, Ste 3
Dover, DE 19904
Phone: 302-678-5008
http://www.gidelaware.com

Name: _____
Last **First** **Middle**

Birth date:_____/_____/_____ **Family Doctor**: _____
mm dd yy

ALLERGIES: _____

_____

MEDICATIONS **(Name, dosage, and how often you take it)**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Circle Yes or No for all Questions below **(Symptoms you are currently having or have had in the last 3 months)**

GI		General		Ears, Nose, Throat		Respiratory	
Abdominal pain	Yes No	Fever	Yes No	Ear pain	Yes No	Shortness of breath	Yes No
Nausea	Yes No	Chills	Yes No	Hearing problem	Yes No	Cough	Yes No
Vomiting	Yes No	Night sweats	Yes No	Nasal congestion	Yes No	Wheezing	Yes No
Gas	Yes No	Fatigue	Yes No	Nasal discharge	Yes No	**Genitourinary**	
Bloating	Yes No	Weight loss (unintentional)	Yes No	Hoarseness of voice	Yes No	Difficult urination	Yes No
Heartburn	Yes No	Poor appetite	Yes No	Recurrent sore throat	Yes No	Blood in urine	Yes No
Diarrhea	Yes No	**Eyes**		**Cardiac**		Frequency in urination	Yes No
Constipation	Yes No	Blurred vision	Yes No	Chest pain	Yes No	Nighttime urination	Yes No
Black stools	Yes No	Eye drainage	Yes No	Leg swelling	Yes No	Urinary incontinence	Yes No
Blood in stool	Yes No	Eye pain	Yes No	Palpitations	Yes No	**Skin**	
Difficulty Swallowing	Yes No	**Neurologic**		Recent heart attack	Yes No	Skin rash	Yes No
Painful swallowing	Yes No	Dizziness / Fainting / Both	Yes No	**Hematologic / Lymphatic**		Jaundice	Yes No
Musculoskeletal		Headaches	Yes No	Easy bruising	Yes No	Itching / Dry Skin / Both	Yes No
Joint pain	Yes No	Seizures	Yes No	Anemia	Yes No	**Endocrine**	
Back pain	Yes No	Weakness	Yes No	Excessive bleeding	Yes No	Heat or Cold intolerance	Yes No
Muscle aches	Yes No	History of falls	Yes No	Swollen lymph nodes	Yes No	Excessive thirst or hunger	Yes No

Past Medical History		**Past** Surgical History		Family History	
Colon polyps	Yes No	Appendectomy	Yes No	Colon cancer	Yes No
Acid Reflux Disease (GERD)	Yes No	C-section	Yes No	Heart disease	Yes No
History of stomach ulcers	Yes No	Gallbladder surgery	Yes No	High blood pressure	Yes No
High blood pressure	Yes No	Hysterectomy	Yes No	Diabetes	Yes No
High cholesterol	Yes No	Cardiac Bypass	Yes No	Asthma	Yes No
Heart disease **Specify Type:**_____	Yes No	Joint replacement **Which Joint:** _____	Yes No	Arthritis	Yes No
Asthma / COPD / BOTH **Circle one applicable**	Yes No	Valve replacement **Which Valve:** _____	Yes No	Ulcers	Yes No
Sleep apnea	Yes No	Hernia repair	Yes No	Gall stones	Yes No
Diabetes	Yes No	Upper GI Endoscopy	Yes No	Skin cancer	Yes No
Anxiety / Depression / BOTH **Circle one applicable**	Yes No	Colonoscopy	Yes No	Cervical cancer	Yes No
Arthritis	Yes No	Sigmoidoscopy	Yes No	Breast cancer	Yes No
Thyroid problem	Yes No	Cardiac catheterization	Yes No	Ovarian cancer	Yes No
LIST ANY OTHER MEDICAL CONDITIONS		**LIST ANY OTHER SURGERIES**		Prostate cancer	Yes No

Marital Status

S ☐ **M** ☐ **W** ☐ **D** ☐ **Sep** ☐

Smoking **Yes** **No**

How many cigarettes daily?

_____

Alcohol Use **Yes** **No**

How often?

_____

Drug use **Yes** **No**

_____

Patient's Signature

_____

Date