Pioneer GI Clinic, APC
1200 Airport Heights Drive Ste 210
Anchorage, AK 99508

www.pioneergiclinic.com

Phone 907 562-6001
Fax 907 562-6002
office@pioneergiclinic.com

Medical History

Name: ____ **DOB**: ______________________

Primary Care Provider: ____

Referring Provider: ____

Reason for Visit: ____

Medication List: ❑ **I am not currently taking any medications**

Name of Medication:	Dose:
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

Medical History:

❑ Anemia
❑ Anxiety Disorder
❑ Artificial Joints
❑ Acid Reflux
❑ Barrett's Esophagus
❑ Bleeding Disorder
❑ Blood Transfusion
❑ C-Diff
❑ Colon Cancer
❑ Colon Polyps
❑ COPD/Emphysema
❑ On Oxygen
❑ Crohn's Disease
❑ Diabetes
❑ Diverticulitis
❑ Heart Attack
❑ Heart Stents
❑ Heart Valve Repl.
❑ Heart Bypass
❑ Hepatitis ____
❑ Hiatal Hernia
❑ High BP
❑ Blood Clots
❑ Tuberculosis
❑ HIV Infection
❑ Defibrillator
❑ Irritable Bowel
❑ Kidney Disease
❑ Liver Disease
❑ Morbid Obesity
❑ MRSA
❑ Pacemaker
❑ Seizure Disorder
❑ Sleep Disorder
❑ Stomach Cancer

Drug Allergies: ❑ **NKDA (No Known Drug Allergies)**

Allergic to:	Reaction:
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

Surgical History: ❑ **No Past Surgical History**

❑ Upper Endoscopy
❑ Colonoscopy
❑ Colorectal Surgery
❑ Bowel Surgery
❑ Abdominal Surgery
❑ Appendix Removal
❑ Gallbladder Removal
❑ Weight-loss Surgery
❑ Hysterectomy
❑ C-Section
❑ Hernia Repair
❑ Heart Surgery
❑ Tonsillectomy
❑ Oral Surgery
❑ Artificial Joint(s)
❑ Other: __________

Hospitalizations Not Accompanied by a Surgery: ❑ **Denies Hospitalizations**

____
____
____

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Name: ____ **DOB**: ________________________

Family History:

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Barrett's Esophagus						
Cancer (Specify Type)						
Celiac						
Cirrhosis						
Colon Polyps						
Crohn's/Colitis						
Depression/ Anxiety						
Diabetes						
Gallbladder Disease						
Hepatitis (Specify Type)						
High Blood Pressure						
High Cholesterol						

Social History:

Tobacco:

❑ Nonsmoker/never smoker ❑ Formerly Smoked or Vaped: When did you quit? ___________
❑ Currently Smokes or Vapes: How many per day? _________ Per week? _____________
❑ Chewing Tobacco: How many cans in a week? ______________

Alcohol Use:

Did you have a drink containing alcohol in the past year?
❑ Yes ❑ No

How often did you have a drink containing alcohol in the past year?
❑ Never ❑ Monthly or less ❑ 2-4 times a month ❑ 2-3 times per week ❑ 4+ times a week

How many drinks did you have on a typical day when you were drinking in the past year?
❑ 1 or 2 ❑ 3 or 4 ❑ 5 or 6 ❑ 7 to 9 ❑ 10 or more

How often did you have six or more drinks on one occasion in the past year?
❑ Never ❑ Less than monthly ❑ Weekly ❑ Daily or almost daily

Drug Use:

In the past year have you used illegal drugs or marijuana? ❑ No ❑ Yes, Last use: ____________
Do you drink caffeinated beverages? ❑ No ❑ Yes, Frequency:_____________

Other:

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Partner ❑ Widow
Occupation: ____