PATIENT HEALTH HISTORY FORM GASTROENTEROLOGY CONSULTANTS, P.C.

To our patients: Welcome to our practice. Please take your time to complete this form. If you have any questions, please ask for assistance. Thank you.

LAST NAME FIRST NAME MIDDLE INITIAL/NAME

Who referred you to our office? _____ **TODAY'S DATE:** _____

Please list any other physicians involved in your care: _____

DATE OF BIRTH: _____ **PLACE OF BIRTH:** _____ **OCCUPATION** _____

MARITAL STATUS: ___Single ___Married ___Separated ___Widow/Widower ___Divorced ___Partnered

REASON FOR VISIT: Please describe the problem which prompted your visit? _____

Please list any lab tests, procedures or X-ray/radiology studies performed (e.g. by another physician or ER visit), that may relate to your current problem: _____

Pharmacy name:_____ **Phone**:_____

MEDICATIONS: Please list all prescribed **OR over-the-counter** medications/supplements (including vitamins and herbal compounds) prescribed or taken recently. **Please include the dose and frequency for each item listed.**

DO YOU TAKE: **Aspirin? [ ] YES [ ] NO** **Anti-inflammatory pain medications (e.g. *Motrin, Advil*, etc.)? [ ] YES [ ] NO**

ALLERGIES TO MEDICATIONS:

OTHER ALLERGIES: _____

Any problems with iodine or intravenous contrast (dye)? [ ] YES [ ] NO Novocaine? [ ] YES [ ] NO

Have you ever experienced any problems with anesthesia? [ ] YES [ ] NO Explanation: _____

SURGICAL HISTORY: Please list **ANY** operations/surgical procedures performed in the past?

YEAR	TYPE OF SURGERY	SURGEON/HOSPITAL (If known)

HOSPITALIZATIONS: Please list any medical illnesses that required hospitalization (other than for surgery or childbirth)

DATE OF LAST COLONOSCOPY: _____ **or [ ]** Never **REASON FOR EXAM:** _____

PHYSICIAN WHO PERFORMED EXAM: _____ **FINDINGS:** _____

Name:_____ **Date of Birth:** _____

Other major medical illnesses or problems not included above:

_____

_____

_____

_____

_____

FAMILY HISTORY:

Any member of your **family** (including parents, grandparents, siblings and children) ever had the following?

Illnesses affecting **OTHER** family members	Relationship to you?	How old when diagnosed?
Colon polyps or cancer of the colon		
Breast cancer		
Cancer – other type (describe part of body affected)		
Ulcer disease		
Liver diseases (cirrhosis, hepatitis, etc.)		
Inflammatory bowel disease (Crohn's or ulcerative colitis)		
Gallbladder disease or prior gallbladder surgery		
Hypertension/high blood pressure		
Heart disease		
Diabetes		
Mental / psychiatric disorder(anxiety, depression, suicide, etc.)		
Drug or alcohol addiction		
Bleeding tendency		
Obesity		

Any other important illness(es) _____

YOUR PERSONAL HABITS:

Smoking: Do you **now, or have you ever** been a smoker? ..... **[ ] YES** **[ ] NO, I NEVER SMOKED**

Average use (estimate): _____ packs each day for approximately _____ years

If you are a **former** smoker, when did you stop? _____.

Alcohol: Do you drink any alcoholic beverages? ..... **[ ] YES** **[ ] NO**

Quantity? (please **estimate** the **average** amount) : _____ mixed drinks _____ glasses of wine _____ beer

How often do you drink this amount? (*circle* one answer) **per** DAY / WEEK / MONTH / YEAR

Have you ever been told or thought that you were an alcoholic? ..... **[ ] YES** **[ ] NO**

Drugs: Have you **ever** (EVEN ONCE) used a needle/syringe to inject street drugs? ..... **[ ] YES** **[ ] NO**

Do you now or have you ever used other illicit, illegal or "recreational" drugs? ..... **[ ] YES** **[ ] NO**

Please explain: _____

CLINICAL NOTES [FOR OFFICE USE ONLY]:

Name:_____ **Date of Birth:** _____

REVIEW OF SYSTEMS: These are some general health questions– please indicate with an **X** or [***check mark***] if **YOU** have currently or in the past experienced (*to a significant degree*) the following problems. Please provide details as appropriate.

CONSTITUTIONAL:

_____ Significant change in appetite? .....
_____ Have you had any **recent** weight change?.....
_____ lbs [ ] Loss [ ] Gain Since when? _____
_____ Recent fever? .....
_____ Night sweats? .....

SKIN DISORDERS:

_____ Eczema? .....
_____ Hives? .....
_____ Rash requiring treatment? .....
_____ Unexplained itching? .....
_____ Skin cancer? .....

HEAD-EYES-EARS-MOUTH-NOSE:

_____ Any serious head injury? .....
_____ Difficulty seeing? .....
_____ Eyeglasses or contact lenses?.....
_____ Cataracts or glaucoma.....
_____ Any hearing loss? .....
_____ Loss of smell? .....
_____ Mouth sores? .....

CARDIOVASCULAR:

_____ High blood pressure? .....
_____ A racing heart/palpitations? .....
_____ Chest pains or tightness with exertion (walking/ climbing)? .....
_____ Waking up at night short of breath? .....
_____ Swollen feet or ankles? .....
_____ Leg cramps or leg discomfort with walking? .....
_____ Heart murmur? .....
_____ Artificial heart valve? .....
_____ Any infection of a heart valve? .....
_____ Heart attack? .....
_____ Pacemaker? .....

RESPIRATORY:

_____ Wheezing or asthma? .....
_____ Coughing up a lot of phlegm (sputum).....
_____ Coughing up blood? .....
_____ Chronic bronchitis? .....
_____ Emphysema? .....
_____ Tuberculosis? .....
_____ Awakened at night with coughing or choking?.....

GASTROINTESTINAL:

_____ Hepatitis (liver infection) Type A, B or C or jaundice? .....
_____ Cirrhosis (scarring of the liver)? .....
_____ Other liver problem or abnormal liver tests? .....
_____ Disease of the pancreas (including pancreatitis)? .....
_____ Gallbladder problems/stones? .....
_____ Problems swallowing food? .....
_____ Heartburn or indigestion? .....
_____ Bloating? .....
_____ Abdominal pain? .....
_____ Recent changes in bowel movements? .....
_____ Frequent use of laxatives or enemas?.....
_____ Black or tarry bowel movements? .....
_____ Blood in your stools/bowel movements? .....
_____ Colon polyps? .....
_____ Stomach/duodenal ulcers? .....
_____ Vomiting blood? .....
_____ Milk / lactose intolerance? .....

PSYCHIATRIC:

_____Hospitalized for nervous breakdown? .....
_____Tension/Anxiety/Depressive Disorder? .....
_____ Bipolar Disorder? .....
_____ Schizophrenia? .....
_____ Ever attempted suicide or serious thoughts about suicide? ...

ENDOCRINE:

_____ Thyroid disease? .....
_____ Diabetes requiring insulin? .....
_____ Diabetes requiring pills/diet? .....
_____ Any unusual sweating? .....
_____ Calcium or bone problems? .....

HEMATOPOIETIC/LYMPHATIC:

_____ Anemia or history of anemia?
_____ Blood transfusions **EVER** in the past.....
When? _____
_____ Tendency to bleed easily when cut? .....
_____ Blood clotting disorder? .....
_____ Are you known to be HIV (AIDS antibody positive)? .....
_____ Swelling of any lymph glands? .....

Name: _____Date of Birth:_____

MUSCULOSKELETAL:

_____ Back pain (as a frequent or serious/continuing problem)? .....

_____ Muscle weakness or muscle disease? .....

_____ Arthritis? .....

_____ Stiff or painful muscles or joints? .....

_____ Joints ever swollen? .....

When was your last bone density test (for osteoporosis)? _____

Was it normal? YES NO _____

GENITOURINARY:

_____ Kidney disease? .....

_____ Kidney stones or past history of kidney stones? .....

_____ Painful or difficult urination? .....

_____ Blood in your urine? .....

(***FOR MEN ONLY):***

_____ Weak or very slow urine stream? .....

_____ Prostate trouble? .....

_____ Discharge from your penis? .....

_____ Swelling or lumps in your testicles? .....

_____ Painful testicles? .....

NEUROLOGICAL:

_____ Epilepsy or seizures?.....

_____ Stroke? .....

_____ Frequent or severe headaches? .....

_____ Dizziness or blackout spells?.....

GYNECOLOGIC (*FOR WOMEN ONLY*):

When was your last menstrual period?_____ Was it normal? YES NO

When was your last PAP smear?_____ Was it normal? YES NO

When was your last mammogram?_____ Was it normal? YES NO

Pregnancies : Total # pregnancies _____

____Births; ____ Miscarriages; ___ Abortions

_____ Excessive bleeding with your periods? .....

_____ Bleeding between your periods? .....

_____ Lumps in your breasts? .....

_____ Cancer in the female organs? .....

_____ **Do you think you may be pregnant?**

Immunizations:

_____ Influenza ..... year_____

_____ Pneumonia vaccine .....year_____

_____ Hepatitis A.....year _____

_____ Hepatitis B.....year _____

_____ Shingles..... year _____

_____ Tetanus ..... year _____

If there are any other medical problems or questions you would like to address with the physician or staff, please use the space below to record your information:

This information will be kept in your chart, and may be easily updated in the future.
We welcome any comments or suggestions that might improve the quality of your visit.
Thank you for your cooperation.

Reviewed by _____ DATE _____