



ADVANCED GI

SPECIALISTS IN GASTROENTEROLOGY & HEPATOLOGY

MEDICAL HISTORY FORM

Date: _____

Legal Name: _____

Date of Birth: _____ Age: _____ Referring Physician/PCP: _____

Mode: ambulatory _____ wheel chair _____ stretcher _____

Do you need an interpreter? Yes _____ No _____ If Yes, arranged? _____ Refused: _____

Reason for Visit Today _____

Past Medical History *Check if you have a history of any problems listed below*

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney disease/Dialysis |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Tuberculosis/PPD |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Colon cancer | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Colon polyps | <input type="checkbox"/> Arthritis/Rheumatoid |
| <input type="checkbox"/> Antibiotics before dental work | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Irritable/spastic bowel | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> COPD/Emphysema/Asthma | <input type="checkbox"/> GERD/Reflux | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Hypo/Hyperthyroid | <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Clotting disorder | <input type="checkbox"/> Prostate cancer | <input type="checkbox"/> Other cancer _____ |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Uterine cancer | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> DVT/PE | | |

Past Surgical History *Check if you have had any of the surgeries below and list year of your surgery*

- | | |
|---|--|
| <input type="checkbox"/> Gallbladder removal _____ | <input type="checkbox"/> Mastectomy/Lumpectomy _____ |
| <input type="checkbox"/> Appendectomy _____ | <input type="checkbox"/> Hysterectomy _____ |
| <input type="checkbox"/> Colon or bowel resection _____ | <input type="checkbox"/> Ovary removal _____ |
| <input type="checkbox"/> Ulcer surgery _____ | <input type="checkbox"/> C-Section _____ |
| <input type="checkbox"/> Artificial Joint _____ | <input type="checkbox"/> Tubal ligation _____ |
| <input type="checkbox"/> Heart bypass _____ | <input type="checkbox"/> Hernia Repair _____ |
| <input type="checkbox"/> Artificial heart valve _____ | <input type="checkbox"/> Hemorrhoid removal _____ |
| <input type="checkbox"/> Coronary Stent _____ | <input type="checkbox"/> Colonoscopy _____ |
| <input type="checkbox"/> Upper Endoscopy _____ | <input type="checkbox"/> Other _____ |

Current Medications *Include prescription, over the counter, home and herbal remedies*

Medications and Food Allergies *Include type of reaction* No known allergies

Family Medical History *Check if a blood relative has had a history of any problem listed below*

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Pancreatic problem |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Gallbladder problem |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Uterine Cancer | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Stomach Cancer | <input type="checkbox"/> Other _____ |



Social History

Smoking: Don't smoke None now
 Currently, how many/day? _____ # of years? _____
 In the past, how many/day? _____ # of years? _____
 When did you quit? _____

Alcohol: Don't drink None now
 How many cocktails/beer/wine _____ daily/weekly/monthly/yearly (Circle one)
 Cups of coffee/day _Caffeinated soft drinks/day _____

History of recreational drug use? None IV drugs _____ Intranasal _____ Other _____

Occupation _____ Disabled Retired Unemployed

Marital Status: Single Married Divorced Widowed Domestic partnership

Children ages and health _____

Review of Systems *Check symptoms you are currently having or have had in the last 3 months*

- Fever
- Weight loss-unintended
- Weight gain
- Rash
- Itching
- Jaundice/Yellowing of eyes
- Swelling in neck
- Sores in mouth
- Ringing in ears
- Vertigo
- Difficulty hearing
- Nose bleeds
- Pain in throat
- Hoarseness
- Glaucoma/Cataracts
- Cough
- Shortness of breath
 - with exertion
 - when laying down
 - at night when sleeping
- Wheezing
- Chest pain
- Swelling in legs
- Pain in calf when walking

- Nausea
- Vomiting
- Loss of appetite
- Heartburn
- Pain when swallowing
- Food sticking in chest
- Abdominal pain
 - after eating
 - before eating
 - at night
- Abdominal bloating/swelling
- Diarrhea
 - at night
- Constipation
- Blood in stool
- Oily stools
- Rectal pain/pressure
- Leakage of stool
- Loss of bladder control
 - when coughing/laughing
- Burning with urination
- Frequent urination
- Blood in urine
- Urinating at night
- Easy bruising

- Men:
- Slow urine stream
 - Difficulty with erection
- Women:
- Last period _____
 - Irregular periods
 - Heavy menstrual bleeding
 - Painful intercourse
 - Joint pain/swelling
 - Nervousness
 - Depression
 - Insomnia
 - Blackouts
 - Headaches
 - Difficulty speaking
 - Tremors
 - Loss of body hair
 - Increased thirst
 - Heat or cold intolerant
 - Other _____
 - Other _____
 - All others negative

Patient signature _____ MD/PA signature _____

Date _____ Date _____