Rm#:_____
EGD/Colonoscopy:_____
Colonoscopy:_____

PATIENT HISTORY FORM

Date of Office Consultation: _____ **Date Form Completed:** _____ **Patient Age** : _____
Last Name:_____ **First Name**:_____ **Middle Initial:** _____
Referred By: _____
Primary Care Doctor: _____
Please provide name(s) of other physician(s) that you have visited within the last year:
_____

- **Reason(s) for your visit to a Gastroenterologist (please include duration of your symptoms if applicable**):

_____
_____

- **Have you started any new medications (prescription, non-prescription, vitamins, probiotics and supplements) within 3 months of the onset of your symptoms? ____ Yes ____ No**
  If yes, please list only those medications (including antibiotics) you started within 3 months of the onset of your symptoms: _____

_____
_____

- **For FEMALE patients, is there any correlation between your symptoms and your menstrual period (if applicable)? ____ Yes ____ No**
  If yes, please briefly describe: _____

_____

Have you been experiencing any of the following (please place a check mark next to those that apply to you):

____ Nausea
____ Vomiting
____Burning in chest
____ Acid or bitter taste in the back of your throat
____Voice hoarseness
____ Awakening in the middle of the night with coughing or shortness of breath
____ Sensation of food being stuck in your throat or chest after swallowing
____Pain when you swallow
____Feeling full shortly after starting a meal
____Loss of appetite
____Chest pain
____Shortness of breath
____Coughing
____Abdominal bloating
____Abdominal pain
____Diarrhea
____Constipation
____Thinning of the stool on a consistent basiis
____Rectal bleeding
____ Pain in rectal area
____Black stool
____Unintentional weight loss
____Fever and/or chills
____Stool incontinence (i.e. loss of control of bowel movements
____Other: _____
_____
_____
_____
_____

Please describe any other symptoms you have been experiencing that are not listed above: _____
_____
_____
_____

For office use only

Weight: _____ *Height:* _____ *BMI:* _____ *Temp:* _____ *BP:* _____ *HR:* _____ *Other:* _____

Medical Clearance: ____*Yes* ____*No* *Diabetic:* ____*Yes* ____*No Type I or II* *Insulin dependent:* ____*Yes* ____*No*

- **For FEMALE patients only:**
  Date of last menstrual period: _____
  Are you or could you be pregnant at this time? ____ Yes ____ No
  Date of your last gynecologic exam: _____
  Date of last mammogram: _____

Please check all that may apply to you:

- **Heart Conditions:**

____ Heart Attack(s)
If yes, date(s): _____
____ Heart murmur
If yes, date(s): _____

____ Aortic Stenosis

____ Heart arrhythmia
If yes, what type? _____

____ Mitral Valve prolapse

____ Taking blood thinners
If yes, name of med: _____

- **Heart Procedures:**

____ Stents
If yes, date: _____
____ Heart bypass surgery
If yes, date: _____

____ Angioplasty
If yes, date: _____
____ Pacemaker or ICD
If yes, date: _____

____ Heart ablation
If yes, date: _____
____ Heart valve surgery/procedure
If yes, date: _____

- **Heart Tests:**

____ Stress Test
If yes, date: _____

____ Echocardiogram
If yes, date: _____

____ Holter Monitor
If yes, date: _____

- **Past Medical History (please place a check mark next to those that apply to you):**

____ Blood clotting disorder
If yes, type: _____
____ Excessive bleeding during procedure or surgery. If yes, name of procedure and date when occurred _____
____ Angina
____ Congestive Heart Failure
____ Fainting
____ Rheumatic Fever
____ High Blood Pressure
____ Elevated Cholesterol
____ Pneumonia
____ Asthma
____ Emphysema
____ Sleep Apnea
____ Anemia
____ Blood Transfusion
If yes, year: _____
____ Thyroid Disease;
Underactive or Overactive
____ Diabetes: Type _____
Insulin Dependent ____Yes ____No
____ Stroke

____ Seizure Disorder
____ Head Injury
____ Migraine Headaches
____ Kidney Stones
____ Kidney Failure
____ HIV infection
____ Herpes
____ Mononucleosis
____ Tuberculosis
____ Psoriasis
____ Infection with organism resistant to antibiotics? If yes, please list: _____
____ Endometriosis
____ Ovarian Cyst
____ Lupus
____ Gout
____ Arthritis

____ Leukemia or Lymphoma
____ Schizophrenia
____ Fibromyalgia
____ Depression
____ Bipolar Disorder

____ Transplant of any organ?
Please specify: _____
____ Hip Replacement or any other prosthesis? Please specify: _____
_____
____ Spine problems
____ Cancer
If yes, type: _____
Diagnosis date: _____
Surgery? Type: _____
Treatment? Type: _____
(chemotherapy/radiation)
Date(s) of treatment: _____
____ MRSA
Diagnosis date: _____
Treated? ____Yes ____No
Location of infection? _____
_____

Have you ever been tested for the AIDS virus? ____ Yes ____ No. _____
Have you received antibiotic prophylaxis for procedures, including dental? ____ Yes ____ No
If yes, please describe: _____
_____
Please describe any other medical disorders not listed above: _____
_____

- **History of Gastrointestinal, Digestive and Liver Diseases** (place check next to those that apply to you)

____ Colon Cancer	____ Ulcers	____ Celiac Sprue
____ Colon Polyps	____ Helicobacter Pylori Infection	____ Gallstones
____ Colon Surgery	____ Stomach Surgery	____ Gallbladder Surgery
____ Ulcerative Colitis	____ Stomach Cancer	____ Hepatitis ___ A, ___B, or ___C
____ Crohn's Disease	____ Barrett's' Esophagus	____ Other Liver Disease
____ Diverticulosis	____ Acid Reflux (GERD)	____ Hemorrhoids
____ Diverticulitis	____ Hiatal Hernia	____ Achalasia
____ Pancreatitis	____ Removal of Appendix	

Please describe any other gastrointestinal, digestive, liver disease or surgery not listed above: _____
_____

- **History of Gastrointestinal and Liver Procedures/Radiologic Studies (please give dates of any of the following procedures/studies you have completed):**

Flexible Sigmoidoscopy: _____ Barium Enema: _____
Colonoscopy: _____ Liver Biopsy: _____
CAT Scan: _____ MRI: _____
Pelvic Ultrasound: _____ Other: _____
Upper Endoscopy: _____
Upper GI series (x-ray after swallowing barium):_____

- **Please list any prior hospitalizations:**

Reason for Hospitalization	Date
_____	_____
_____	_____
_____	_____

- **Please list any prior surgeries (not already listed):**

Please describe surgical procedure performed	Date
_____	_____
_____	_____
_____	_____

- **Please provide consent to having your medication list imported**: ____ Yes ____ No
- **Are you allergic to any medications?**

If yes, please list: _____
_____

- **Do you have any other allergies?** ____ Yes ____ No

If yes, please list: _____
_____

- **Do you take aspirin?** ____ Yes ____ No. Dose: _____ 81 mg or _____ 325 mg

How often do you take aspirin? (i.e. daily, 1 x week, etc.): _____

- **Do you take Advil, Aleve, Motrin or similar anti-inflammatory medication?** ____ Yes ____ No

If yes, name: _____ Dose: _____ How often? (i.e. daily, 1 x week, etc.): _____

- **Do you take antacids or acid blocking medication such as Mylanta, Zantac, Pepcid, Prilosec or Prevacid?**

____ Yes ____ No If yes, name of medication: _____ Dose: _____

How often? (i.e. daily, 1 x week, etc.): _____

- **Please provide the names and doses of the medications you are currently taking (including prescription, non-prescription, vitamins, probiotics and supplements):**

Name of Medication/Supplement	Dose (ex. 10mg, 20mg)	Frequency (ex. 1 per day, 2 per day)	Date Started (Estimate)

OTHER HISTORY

- **Do you smoke cigarettes**? ____ Yes ____ No

If yes, how many cigarettes per day? _____

- **Are you a former smoker?** ____ Yes ____ No

If yes, how many cigarettes per day? _____ For how many years? _____ When did you stop? _____

- **Do you drink alcoholic beverages?** ____ Yes ____ No

If yes, how many drinks per day/week/month? (measured as 1 ounce scotch = 1 beer = 1 glass of wine) _____

Occupation: _____ Marital Status: _____ Number of Children: _____

Family History

Gastrointestinal, digestive, or liver disease:

Please list the relatives who have been diagnosed with the following disorders and age at which he/she was diagnosed:

Colon Cancer: _____ Ulcers: _____

Colon Polyps: _____ Helicobacter Pylori Infection: _____

Ulcerative Colitis: _____ Liver Disease: _____

Crohn's Disease: _____ Gallbladder Disease: _____

Other gastrointestinal, digestive or liver disease not described above: _____

- **Your Family's General Medical History:**

	Age	Medical Problems	Deceased?	If yes, cause?
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brother/Sister	_____	_____	_____	_____
(specify)	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Children	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Other (Aunt/Uncle,				
Grandparents)	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

- **Dietary History**

Please describe the foods you typically have for the following meals:

	Food	Beverage
Breakfast	_____	_____
Lunch	_____	_____
Dinner	_____	_____
Snacks	_____	_____

- **Do you have a history of milk or other food intolerance?**

If yes, please describe: _____

_____

- **Do any of your symptoms occur either during or shortly after meals?**

If yes, please describe: _____

_____

- **Do you chew gum or consume other sugar containing products on a regular basis?**

If yes, please describe what you consume and how often: _____

_____