Rm#\_\_\_\_\_\_

EGD/Colonoscopy\_\_\_\_\_Colonoscopy\_\_\_\_\_\_\_\_

**PATIENT HISTORY FORM**

**Date of office consultation:**\_\_\_\_\_\_\_\_\_\_\_\_  **Date form completed:** \_\_\_\_\_\_\_\_\_\_\_\_ **Patient age:** \_\_\_\_\_\_\_\_\_\_\_\_

**Last name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Middle initial:** \_\_\_\_\_\_\_\_\_\_\_

**Primary Care Doctor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide name(s) of other physicians(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 medication (prescription, nonprescription, 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**For FEMALE patients, is there any correlations between your symptoms and your menstrual period (if applicable)?** \_\_\_\_Yes \_\_\_\_No

If yes, please briefly describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_ Nausea \_\_\_\_ Loss of appetite \_\_\_\_ Stool incontience (I.e. loss of control

\_\_\_\_ Vomiting \_\_\_\_ Chest pain of bowel movements)

\_\_\_\_ Burning in chest \_\_\_\_ Shortness of breath \_\_\_\_ Other:

\_\_\_\_ Acid or bitter taste in the \_\_\_\_ Coughing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

back of your throat \_\_\_\_ Abdominal bloating \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Voice hoarseness \_\_\_\_ Abdominal pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Awakening in the middle \_\_\_\_ Diarrhea \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

of the night with coughing or \_\_\_\_ Constipation \_\_\_\_ COVID- 19 Vaccine

shortness of breath \_\_\_\_ Thinning of the stool \_\_\_\_ Johnson & Johnson

\_\_\_\_ Sensation of food being on a consistent basis \_\_\_\_ Moderna Date: 2nd dose\_\_\_\_\_\_\_\_\_

stuck in your throat or chest \_\_\_\_ Rectal Bleeding \_\_\_\_ Pfizer Date: 2nd dose \_\_\_\_\_\_\_\_\_\_\_

after swallowing \_\_\_\_ Pain in rectal area \_\_\_\_ Booster Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Pain when you swallow \_\_\_\_ Black stool \_\_\_\_ Non- Vaccinated

\_\_\_\_ Feeling full shortly after \_\_\_\_ Unintentional weight loss

starting a meal \_\_\_\_ Fever and/ or chills

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***For office use only***

Weight: \_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_ BMI: \_\_\_\_\_\_\_ Temp: \_\_\_\_\_\_\_ BP: \_\_\_\_\_\_\_\_ HR: \_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_

Medical Clearence: \_\_\_\_Yes \_\_\_\_No Diabetic\_\_\_\_Yes \_\_\_\_No Type I or II Insulin dependent: \_\_\_\_Yes \_\_\_\_No

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| * **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
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| **Please check all that may apply to you:** |  |

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| * **Heart Conditions:** | | |
| \_\_\_\_ Heart Attack(s)  If yes, date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ Aortic Stenosis | \_\_\_\_ Mitral Valve prolapse |
| \_\_\_\_ Heart murmur  If yes, date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ Heart arrhythmia  If yes, what type? \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ Taking blood thinners If yes, name of med: \_\_\_\_\_\_\_\_\_\_ |
| * **Heart Procedures:** | | |
| \_\_\_\_ Stents  If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ Angioplasty  If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ Heart ablation  If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_ Heart bypass surgery  If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ Pacemaker or ICD  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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| * **Past Medical History (please place a check mark next to those that apply to you):** | | |
| \_\_\_\_ Blood clotting disorder | \_\_\_\_ Seizure Disorder | \_\_\_\_ Transplant of any organ? |
| If yes, type: \_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ Head Injury | Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_ Excessive bleeding during | \_\_\_\_ Migraine Headaches | \_\_\_\_ Hip Replacement or any other |
| procedure or surgery. If yes, name | \_\_\_\_ Kidney Stones | prosthesis? Please specify: \_\_\_\_\_\_\_\_ |
| of procedure and date when occurred | \_\_\_\_ Kidney Failure | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ HIV infection | \_\_\_\_ Spine problems |
| \_\_\_\_ Angina | \_\_\_\_ Herpes | \_\_\_\_ Cancer |
| \_\_\_\_ Congestive Heart Failure | \_\_\_\_ Mononucleosis | If yes, type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_ Fainting | \_\_\_\_ Tuberculosis | Diagnosis date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_ Rheumatic Fever | \_\_\_\_ Psoriasis | Surgery? Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_ High Blood Pressure | \_\_\_\_ Infection with organism | Treatment? Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_ Elevated Cholesterol | resistant to antibiotics? If yes, please | (chemotherapy/radiation) |
| \_\_\_\_ Pneumonia | list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date(s) of treatment: \_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_ Asthma | \_\_\_\_ Endometriosis | \_\_\_\_ MRSA |
| \_\_\_\_ Emphysema | \_\_\_\_ Ovarian Cyst | Diagnosis date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_ Sleep Apnea | \_\_\_\_ Lupus | Treated? \_\_\_\_Yes \_\_\_\_No |
| \_\_\_\_ Anemia | \_\_\_\_ Gout | Location of infection? \_\_\_\_\_\_\_\_\_ |
| \_\_\_\_ Blood Transfusion  If yes, year: \_\_\_\_\_\_\_\_\_ | \_\_\_\_ Arthritis | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_ Thyroid Disease; | \_\_\_\_ Leukemia or Lymphoma |  |
| Underactive or Overactive | \_\_\_\_ Schizophrenia |  |
| \_\_\_\_ Diabetes: Type \_\_\_\_\_\_ | \_\_\_\_ Fibromyalgia |  |
| Insulin Dependent \_\_\_\_Yes \_\_\_\_No | \_\_\_\_ Depression |  |
| \_\_\_\_ Stroke | \_\_\_\_ Bipolar Disorder |  |

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| **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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| * **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| * **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):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| * **Please list any prior hospitalizations:** | |
| Reason for Hospitalization | Date |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| * **Please list any prior surgeries (not already listed):** | |
| Please describe surgical procedure performed | Date |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| * **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| * **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 | Frequency | Date Started |
|  | (ex. 10mg, 20mg) | (ex. 1 per day, 2 per day) | (Estimate) |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ |
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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ |

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| * **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.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **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: \_\_\_\_\_\_\_\_\_\_** |

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| **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)** | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |  |  |  | | |

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| * **Dietary History** | | |
| Please describe the foods you typically have for the following meals: | | |
|  | Food | Beverage |
| Breakfast | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Lunch | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Dinner | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Snacks | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| * **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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