Medical CONSULTANTS
Patient Focused • Quality Oriented • Physician Driven

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Gastroenterology History Form

Name: _____ Date: _____
Referring Physician: _____ Date of Birth: _____

Reason for Visit: _____
_____

Medical History: Please check any of the conditions that represent a SIGNICANT problem for you

General	YES	Gastrointestinal	YES	Musculoskeletal	YES
Fever or chills		Abdominal pain		Broken Bones	
Night sweats		Nausea and vomiting		Joint replacement surgery	
Recent weight changes		Heartburn or indigestion		Gout	
Eyes	**YES**	Gallbladder problems		Arthritis	
Glasses or contacts		Trouble swallowing		Bone or joint pain	
Glaucoma		Loss of appetite		**Endocrine**	**YES**
Other eye problems		Diarrhea		Heat or cold intolerance	
Ears, Nose Mouth	**YES**	Constipation		Hot flashes	
Nose bleeds		Rectal pain		Excessive thirst	
Sinus problems		Hemorrhoids		Flushing	
Earache		Blood in stool		Changes in body hair	
Dentures		Tarry stools		**Skin**	**YES**
Hearing loss		**Genitourinary**	**YES**	Rash, dryness or itching	
Respiratory	**YES**	Painful urination		Jaundice	
Cough		Kidney stones		Easy bruising	
Wheezing		Frequency at night		Psoriasis or Eczema	
Shortness of breath		Urgency		Pigment changes	
Asthma		Slow or small stream		**Neurolgic**	**YES**
Cardiovascular	**YES**	Blood in urine		Numbness	
Chest pain		Leaking of urine		Headaches	
Heart palpitations		Poor bladder emptying		Stroke	
Irregular heart beat		Menstrual problems		Dizziness	
Heart attack or failure		Recurrent bladder infections		Paralysis	
Heart murmur		Abnormal vaginal bleeding		**Psychiatric**	**YES**
Heart valve problems		Sexual problems		Depression	
Blood clots				Anxiety	
Feet or ankle swelling				Other	

Please list all of your medications, including over the counter medications (If you need additional space, please bring a list to your appointment.) Include Medication Name, Dosage and Number of times per Day

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list all allergies including medications, food, and environmental

_____ _____
_____ _____
_____ _____

Past Medical History: Please check if you or your family have ever had any of the following

	You	Family		You	Family
Ulcerative Colitis or Crohn's Disease			TB		
Ulcer			High Blood Pressure		
Colon polyps or Colon Cancer			High Cholesterol		
Liver Disease			Diabetes		
Pancreatic Disease			Thyroid Disease		
Bleeding Disorder			Kidney Disease		
Have you ever had a Blood Transfusion			Seizures		
Lung Disease			Psychiatric Disorder		
Heart Disease			Depression		

Number of Pregnancies _____ Number of Live Births _____ Currently using Contraception: Yes ❑ No ❑
Last Tetanus Shot _____ Pneumonia Vaccine _____ Flu Shot _____
Hepatitis A Vaccine _____ Hepatitis B Vaccine _____ TB Skin Test _____

Please list any recent hospitalizations, and surgeries, and an approximate date of hospitalization

Date	Reason for hospitalization or surgery

Family History:

Relative	Age	Living	Deceased	Disease or Cause of Death
Father				
Mother				
Siblings				

Social History:
Marital Status: Single ❑ Divorced ❑ Married ❑ Widow/Widower ❑ Other ❑
Do you smoke? Yes ❑ No ❑ If yes, how many packs per day?_____
Did you smoke? Yes ❑ No ❑ If yes, when did you quit? _____
Do you drink alcohol? Yes ❑ No ❑
If yes, indicate on average how much and circle day, week, or month:
_____Beer per: Day ❑ Week ❑ Month ❑
_____Glasses of wine per: Day ❑ Week ❑ Month ❑
_____Mixed drinks per: Day ❑ Week ❑ Month ❑
Did you use to drink heavily? Yes ❑ No ❑ How long did you drink heavily? _____
When did you quit or cut down on drinking? _____ Do people get annoyed by you drinking? Yes ❑ No ❑
Do you feel guilty about drinking? Yes ❑ No ❑ Do you drink alcohol in the morning? Yes ❑ No ❑
Do you or have you ever-used street drugs? Yes ❑ No ❑ Do you have Tattoos? Yes ❑ No ❑

DO YOU HAVE ANY OTHER PROBLEMS YOU WANT TO DISCUSS? Yes ❑ No ❑

Patients signature_____ Date _____
Physician signature _____ Date _____