# PATIENT HEALTH HISTORY FORM

**To our patients: Welcome to our practice. This is an important document referred to by the doctors and staff who will meet with you. Please take your time to complete this form. If you have any questions, please ask for assistance. Thank you.**

**GASTROENTEROLOGY CONSULTANTS, P.C.**

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: _____

**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:**_____

**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:_____

**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:** _____

**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? .....

**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?**

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** _____

**Reviewed by** _____ **DATE** _____

**Reviewed by** _____ **DATE** _____

**Reviewed by** _____ **DATE** _____

**Reviewed by** _____ **DATE** _____

**Reviewed by** _____ **DATE** _____

**Reviewed by** _____ **DATE** _____