

Gastroenterology Associates

Medical and Family History Form

Please fill in the circles for the appropriate health information

NAME: _____ TODAY'S DATE: _____

CHART NO. _____ DATE OF BIRTH: _____

REASON FOR VISIT _____

Allergies

- | | | | | | | |
|-------------------------------|-------------------------------|------------------------------|--------------------------------|----------------------------------|-----------------------------|-----------------------------------|
| <input type="radio"/> None | <input type="radio"/> Codeine | <input type="radio"/> Iodine | <input type="radio"/> Morphine | <input type="radio"/> Penicillin | <input type="radio"/> Sulfa | <input type="radio"/> Versed |
| <input type="radio"/> Aspirin | <input type="radio"/> Demerol | <input type="radio"/> Latex | <input type="radio"/> Novocain | <input type="radio"/> Propofol | <input type="radio"/> Tape | <input type="radio"/> Other _____ |

Past Medical Illnesses

- | | | | | |
|---|--|--|---|---|
| <input type="radio"/> None | <input type="radio"/> Gallstones | <input type="radio"/> Atrial Fibrillation | <input type="radio"/> High Triglycerides | <input type="radio"/> Rheumatic Fever |
| <input type="radio"/> Anemia | <input type="radio"/> Hepatitis A | <input type="radio"/> Breast Cancer | <input type="radio"/> History of Suicide Attempts | <input type="radio"/> Rheumatoid Arthritis |
| <input type="radio"/> Cirrhosis of Liver | <input type="radio"/> Hepatitis B | <input type="radio"/> Chronic Lung Disease | <input type="radio"/> HIV/AIDS | <input type="radio"/> Seizures |
| <input type="radio"/> Colitis | <input type="radio"/> Hepatitis C | <input type="radio"/> Congestive Heart Failure | <input type="radio"/> Irregular Heart Beat | <input type="radio"/> Melanoma |
| <input type="radio"/> Colon Cancer | <input type="radio"/> Hiatal Hernia | <input type="radio"/> Depression | <input type="radio"/> Kidney Failure | <input type="radio"/> Sleep Apnea |
| <input type="radio"/> Colon Polyps | <input type="radio"/> Irritable Bowel Syndrome | <input type="radio"/> Emphysema | <input type="radio"/> Kidney Stone | <input type="radio"/> Stroke |
| <input type="radio"/> Crohn's Disease | <input type="radio"/> Lactose Intolerance | <input type="radio"/> Glaucoma | <input type="radio"/> Lupus | <input type="radio"/> TB (Tuberculosis) |
| <input type="radio"/> Persistent Diarrhea | <input type="radio"/> Pancreatitis | <input type="radio"/> Gout | <input type="radio"/> Migraines | <input type="radio"/> TB skin Test Positive |
| <input type="radio"/> Diverticulitis | <input type="radio"/> Reflux | <input type="radio"/> Heart Attack | <input type="radio"/> Paralysis | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Diverticulosis | <input type="radio"/> Stomach Ulcer | <input type="radio"/> Heart Murmur | <input type="radio"/> Parkinson's Disease | <input type="radio"/> Uterine Cancer |
| <input type="radio"/> Duodenal Ulcer | <input type="radio"/> Ulcerative Colitis | <input type="radio"/> High Blood Pressure | <input type="radio"/> Phlebitis | <input type="radio"/> Other _____ |
| <input type="radio"/> Fatty Liver | <input type="radio"/> Asthma | <input type="radio"/> High Cholesterol | <input type="radio"/> Pneumonia | |

Previous Surgeries

- | | | | | |
|---|---|---|--|--------------------------------------|
| <input type="radio"/> None | <input type="radio"/> Breast | <input type="radio"/> Heart Stent | <input type="radio"/> Kidney | <input type="radio"/> Tubal Ligation |
| <input type="radio"/> Colonoscopy | <input type="radio"/> C-Section | <input type="radio"/> Heart Valve Replacement | <input type="radio"/> Obesity Surgery | |
| <input type="radio"/> EGD/Upper Endoscopy | <input type="radio"/> Cardiac Surgery | <input type="radio"/> Hemorrhoidectomy | <input type="radio"/> Prostate | |
| <input type="radio"/> ERCP | <input type="radio"/> Right Colon Resection | <input type="radio"/> Hiatal Hernia Repair | <input type="radio"/> Stomach | |
| <input type="radio"/> Liver Biopsy | <input type="radio"/> Left Colon Resection | <input type="radio"/> Hysterectomy Partial | <input type="radio"/> Thyroid | |
| <input type="radio"/> Sigmoidoscopy | <input type="radio"/> Cholecystectomy | <input type="radio"/> Hysterectomy Total | <input type="radio"/> Tonsils | |
| <input type="radio"/> Appendectomy | <input type="radio"/> Heart Bypass Surgery | <input type="radio"/> Joint Surgery/Replacement | <input type="radio"/> Transplant Surgery | <input type="radio"/> Other _____ |

Social History Marital Status:

- Single
- Separated
- Married
- Divorced
- Widowed

Number of Children:

- 1
- 2
- 3
- 4
- 5
- 6+
- None

Social History Exercise:

- I do not exercise
- I walk
- I jog
- I bike
- I swim
- I golf
- I do aerobics
- I lift weights

Social History Alcohol:

- Never
- More than 2 days/week
- Rarely
- Less than 2 days/week
- Daily
- I quit using alcohol

Social History Tobacco:

- I use tobacco products
- I quit using tobacco products
- I have never used tobacco products
- Cigarettes
- Cigars
- Smokeless tobacco

Social History Illicit Drug Use:

- I use illicit drugs
- I quit using illicit drugs
- I have never used illicit drugs
- Injection drug use

Social History Occupation:

Patient Occupation _____ Veteran Retired

REVIEW OF SYSTEMS (Current Symptoms)

Gastrointestinal:

- None
- abdominal pain-upper
- abdominal pain-lower
- abdominal pain-swelling
- anal/rectal pain
- belching
- black stools
- bloating
- change in bowel habits
- constipation
- dairy intolerance
- diarrhea
- difficulty swallowing
- flatulence/gas
- heartburn
- hemorrhoids
- mucous in stool
- nausea
- pain with bowel movement
- rectal bleeding
- rectal urgency
- reflux
- soiling stool/incontinence
- weight loss less than 10 lbs
- weight loss more than 10 lbs
- weight gain less than 10 lbs
- weight loss more than 10 lbs
- vomiting
- Other _____

Urinary:

- None
- blood in urine
- change in urinary frequency
- kidney stones
- nocturnal urination
- pain with urination
- Other _____

MALE

testicle problem

FEMALE

Skin:

- NONE
- dryness
- hives
- itching
- jaundice
- rashes
- suspicious lesions
- Other _____

- sexually transmitted disease
- urinary incontinence

- breast lump
- heavy periods

Cardiovascular:

- None
- chest pain with exertion/angina
- palpitations
- shortness of breath with exertion
- ankle swelling
- heart murmur/as an adult
- shortness of breath when lying flat
- Other _____

Neurological:

- None
- dizziness
- fainting spells
- frequent headaches
- memory disturbance
- numbness in extremities
- seizures
- stroke/weakness
- tremors
- Other _____

Endocrine:

- None
- cold intolerance
- excessive thirst
- hair change/loss
- heat intolerance
- tremors
- Other _____

Constitutional:

- None
- chills
- fatigue
- fever
- loss of appetite
- night sweats
- Other _____

Psychiatric:

- None
- anxiety/panic
- depression
- inability to concentrate
- suicidal thoughts
- Other _____

Eyes:

- None
- blurred vision
- cataracts
- glaucoma
- light sensitivity
- loss of vision
- pain
- wearing glasses/contacts
- Other _____

Hematologic:

- None
- easy bruising
- prolonged bleeding
- swollen glands
- Other _____

Ears, Nose and Throat:

- None
- hearing loss
- hoarseness
- nose bleeds
- sore throat
- Other _____

Musculoskeletal:

- None
- back pain
- joint pain
- muscle pain
- stiffness
- Other _____

Respiratory:

- None
- cessation of breathing when sleeping
- cough up blood
- coughing
- snoring
- wheezing

Immunologic:

- None
- allergies (environmental)
- HIV exposure
- persistent infections
- recurrent hives
- strong allergic reactions

